Mailing Address: 109 State Street

Montpelier, VT 05609-1106 Tel.: (802) 828-2673

Fax: (802) 828-5450



Office Location: One Prospect Street Montpelier, VT 05602

# State of Vermont Board of Medical Practice

June 6, 2002

Anne Hildreth, PA-C

RE:

Physician's Assistant Certification 55-0030584

Dear Anne:

Congratulations! On June 5, 2002, you were presented and approved for certification as a Physician's Assistant in the State of Vermont. Enclosed is your printed certificate. A professional certificate has been sent to your employer. This is to be placed at your place of employment, to be visible for the public.

Physician's Assistant certifications are renewed in January of every even year (no matter when you received your initial certification). You will be sent a renewal form two months prior to the expiration date.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Jenny

Jenny M. Audet

Administrative Assistant

IT IS YOUR RESPONSIBILITY TO NOTIFY THIS BOARD OF ADDRESS CHANGE OR TERMINATION OF EMPLOYMENT.

cc: Cheryl Gibson, M.D.

Enclosure



#### STATE OF VERMONT BOARD OF MEDICAL PRACTICE

#### PROFESSIONAL CERTIFICATE

I hereby certify that the following named person is fully qualified to practice as a Physician's Assistant in the State of Vermont:

#### Anne Sarver Hildreth, PA-C

P.A. Certification Number: 55-0030584

Valid only while working under the supervision of Cherly Gibson, M.D. and Susan Smith, M.D., at Planned Parenthood of Northern New England, 23 Mansfield Avenue, Burlington, VT.

Valid through January 31, 2004.



IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the

#### VERMONT BOARD OF MEDICAL PRACTICE

at Montpelier, in the county of Washington, State of Vermont,

this

6th

of

June

, A.D. 2002

Administrative Assistant

#### Jenny Audet

From: To:

Katherine Silta <katherine.silta@cvosm.org>

Sent:

Jenny Audet (E-mail) <jaudet@medbd.state.vt.us> Thursday, May 30, 2002 12:23 PM

Subject:

Hildreth and Bradley are all set. KAS

Ann Hildreth \$ 055-6030584 May 31,2002

#### Jenny Audet

From: To:

Katherine Silta <katherine.silta@cvosm.org> Jenny Audet (E-mail) <jaudet@medbd.state.vt.us> Wednesday, May 08, 2002 12:26 PM

Sent:

Subject:

You can issue numbers to Krall, Allen, Potter. Hildreth showed up over an hour late and rescheduled for interview....again. Cassie

#### **MEMORANDUM**

TO:

Cassie Silta, PA Board Member

FROM:

Jenny M. Audet, Administrative Assistant N

DATE:

February 5, 2002

SUBJECT:

Anne Hildreth, PA-C

Enclosed is a complete file on Anne Hildreth, PA-C who will be employed by Planned Parenthood of Northern New England, 23 Mansfield Avenue, Burlington, VT.

She has **not** held other licenses in Vermont. Her supervisors will be Cheryl Gibson, MD and Susan Smith, MD.

If you require any further information please feel free to contact me. Thanks.

/jma

Enclosure

Mailing Address: 109 State Street Montpelier, VT 05609-1106

Tel.: (802) 828-2673 Fax: (802) 828-5450



Office Location: One Prospect Street Montpelier, VT 05602

## State of Vermont Board of Medical Practice

February 5, 2002

Anne Hildreth PA-C

Dear Anne:

Your PA application file to work at Planned Parenthood of New England in Burlington, VT appears to be complete.

I have mailed a copy of your application file to the PA Board member Cassie Silta. She will review your application, with particular emphasis on the Scope of Practice. She will than contact you to set up an interview time that is convenient for both of you.

Once you have interviewed and she is satisfied with the results she will contact me to issue you a certificate number. I will notify you immediately and you can begin work. Your paper certificate will be mailed after the next Board Meeting, which held the first Wednesday of each month.

If you have any questions please feel free to contact me at (802) 828-2422.

Sincerely,

Jenny Audet

Administrative Assistant

### PHYSICIAN ASSISTANT STATUS SHEET

DATE RECEIVE	D: 01/12/01	•
	Sarver Hildath PHONE #:	
ADDRESS		
Di	lanned Farenthood of Northern New England	
ADDRESS: 2	3 Mansfield avenue, Burlington, VT 05401	
Initial License in	Vermont? YesNo Application Fee Paid S	
12	Completed Application for Certification as a Physician Assistant in Vermont (Signed & dated)	₹ M'
<u> </u>	Certified Copy of Birth Certificate DOB	
	Employment Contract	
40	Primary Supervisor Physician Application (Signed by PA & Supervisor) M.D.: Charge School Lie #: 40 - 74-65	٠.
<u> </u>	Secondary Supervising Physician Applications M.D.: Susaw Smith Lic#: 42-5990	-
· ·	M.D.:Lic#:	
	M.D.:Lic #:	
	M.D.: Lie #:	
\$	M.D.: Lie #:	
4	Direct Verification of State Licensure  Massachusetta	
-	y 7 Jew Hampshire	
/	Scope of Practice (signed by PA and Primary Supervisor) A detailed description Of the duties and scope of practice to include authority to prescribe medications.	
W		University
- <del>                                    </del>	A. Direct Verification: Certificate of Physician Assistant Education 1	6/10/82
NCCF	given by NCCPA (National Commission on the Certification of Physician Assistants) from	
Nacore Placement	The resident trained amplicants:	
	A. Documentation from the physician in charge of the approximation and the applicant has satisfactorily completed the program.	
	B. Final PA trainee evaluation conducted by the Board ensuring that the cant is qualified by education training and experience to perform the duties outlined in his/her	
scope	e of practice.	541/407
	Two (2) completed reference forms mailed directly to the Board by the Physician. Chary C  Physician Reference Form Number 1  Physician Reference Form Number 2  Charyl Sibson, MDSUSAN	sybson MD Smith MA
A) A	Completed Form A. if applicant answered "yes" in Section III	** <b>***********</b>
V	Child Support/Tax/Unemployment Form Federation Disciplinary C	্ ক •
		***

PL

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

### APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT IN VERMONT PAGE ONE OF SEVEN

FEE: Enclose a check in the amount of \$ 75. initial certification (\$50 if not initial) made payable to the Vermont Board of Medical Practice.

#### 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.
- 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 stale and new documents must be submitted.
- Make a copy of this form and all attachments for your own records.
- Carefully complete the application as false statements are grounds for unprofessional conduct.
- Thank you for your cooperation.

#### **SECTION I**

Name: +//८	DRETH	ANNE	SACU	<u> </u>	
į	(Last)	(First)	(Middle)	(Former)	
Mailing Address:					
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Office Address:	5 Dunning				
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Claronoc (City)	<u>ナ 10 H</u> (Stat	<u> </u>	<u>ර ර ර</u> Code)	<u>3 - 543 - 450</u> (Phone)	<u> </u>
Home Address:			•	<b>,</b> ,	
City, State, Zip Cod	de:				
Daytime Telephone	e Number: ( <u>6</u> 63	542.	4568		<del></del> -
Date of Birth: Mont			_ Day_	Year	
Place of Birth:			Sex:		male
Basis for Licensure	e: 🔀 Unive	ersity Trained - NC			maio
	——————————————————————————————————————	ont Apprenticeshi		••	

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT, PAGE TWO OF SEVEN

### NAME FOR CERTIFICATE - NAME CHANGES - OTHER NAMES CERTIFIED/ LICENSED

	ges? Yes ≮	. No	
Have you ever held a Vermo	ges? Yes ≮	ation?Yes <u>~</u> No l	
	ont Temporary Certifica		f Yes, when:
asahmi	C		
Secondary Supervising Pl	hysician(s)	Secondary Su	pervising Physician's Specialty
List name and specialty o	f secondary supervis	sing physician(s):	And Andrews
		<u> </u>	Datok
Dr. Chonyl Dr. Suscos	$\frac{S \cdot R \cdot S \cdot S}{S \cdot R}$		03/6zp
	Gibson	à.	
List name and specialty o Supervisor's Name	f supervising physic	ian(s):	Supervisor's Specialty
	SUPE	ERVISING PHYSICIANS	
(Name and location of fish	ution) (Froi	m/To-Month/Year)	(Degree)
(Name and location of Instit	hution) /[	To Name to Name	
(Name and location of Insti	tution) (Fro	m/To-Month/Year)	(Degree)
		· · · · · · · · · · · · · · · · · · ·	
(Name and location of Insti	tution) (Fro	/m/To³Month/Year)	(Degree)
<u>Hahremonn</u>	wir. Phi	1a, Ra. 1986.	1982 ASJPAC
	EDUCA	ATION (College Forward)	1
Other Name(s), if any, und	er which you were cert	tified / licensed elsewhere:	NA
Have you ever legally char If Yes, enclose a certified of	nged your name? copy of the legal docum	_ Yes _ 🖄 No nent stating the change.	

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT, PAGE THREE OF SEVEN

#### **TRAINING**

List chronologically residency or other formal medical training programs. Give names, addresses of hospitals, exact dates (month, day, year), and type of training. Include COPIES OF CERTIFICATES.

Name ·	Address	From	To Trainii
List all other (e.g., course	significant training affecting your work as s in such areas as laboratory or x-ray ted	s a physician's assistant chnology, physical therap	y, EMT):
		SES OR CERTIFICATION	
Do you hold, the section b	or have you ever held, a license/certifica elow and send a Verification of Physician	ation in any other state? _ n's Assistant Licensure or	Yes No If yes, c Certification to each state.
State	Certificate/License Number	Date Issued	Status (Active or Inactiv
Mass.		· · · · · · · · · · · · · · · · · · ·	neveruse
<u> Viccia</u>	flessige maristale	N 0 F	Inachie
41990	F got The License	1.0000	end 1 Heron
Are you a gra (CAHEA) or i	aduate of a program accredited by the Cots successor agency? <u>&lt;</u> YesN	ommittee on Allied Health	
Do you hold	a NCCPA Certificate? 🗠 Yes N	lo If yes, attach a copy.	
NCCPA Cert	ficate Number: 101311 E	expiration Date:	
When are yo	u scheduled to begin work in Vermont?	ASAP	-
Have you pre	viously applied for certification in Vermor what name	nt? Yes 🖂 No	***************************************
What has bee	en your physical residence (City, State) ir	n the past ten years?	
nove N.		-	
	1992-2000	C	fact. VT
Have you eve	er discontinued your practice as a physici months?Yes _< No If yes, expli	ian's assistant or physicia	n's assistant trainee for a n
	**************************************	···········	

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT, PAGE FOUR OF SEVEN

#### SECTION II

**PROVIDE A PHOTOGRAPH:** Attach a photograph taken within the last 60 days (head and shoulders). Proofs not acceptable. **Sign the front of the photograph.** 



PHOTOGRAPH

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION - PHYSICIAN'S ASSISTANT, PAGE FIVE OF SEVEN

#### SECTION III

### SECTION III - "Yes" answers to Questions 1 - 24 requires an explanation on the enclosed Form A.

1.	Have you ever applied for and been denied a certification/license to practice as a PA or any healing art?YesX_ No
2.	Have you ever withdrawn an application for a certification/license to practice as a PA or any healing art?YesX_No
3.	Have you ever voluntarily surrendered or resigned a certification/license to practice as a PA or any healing art in lieu of disciplinary action? YesX_No
4.	Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmenta authority, by any hospital or health care facility, or by any professional PA association (international, national, state or local)? YesNo
5.	To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
6.	Have you ever been denied the privilege of taking an examination before any State Medical Examining Board? YesXNo
7.	Have you ever discontinued your education, training, or practice for a period of more than three months?Yes
8.	Have you ever been dismissed or asked to leave a residency training program(s) before completion? Yes _xNo
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
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 patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?  Yes No
12.	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)?
13.	Have you ever been turned down for coverage by a malpractice insurance carrier?  Yes
14.	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? YesK_No
15.	Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses (Note: DWI - Driving While Intoxicated - is NOT a minor offense)? Yes <a href="mailto:X">X</a> _ No
16.	To your knowledge, are you the subject of an investigation for a criminal act?

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION - PHYSICIAN'S ASSISTANT, PAGE SIX OF SEVEN

SECTION III CONTINUED - "Yes" answers to Questions 17 - 24 requires 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
- 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
- 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" 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 five (5) 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.

- Do you have a medical condition which in any way impairs or limits your ability to practice as a PA with reasonable skill and safety? If "yes," please explain.
- Does your use of chemical substance(s) in any way impair or limit your ability to practice as a PA with reasonable skill and safety? If "yes," please explain.
- 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
- 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.
- 21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voveurism? If "yes," please explain.
- 22. Are you currently engaged in the illegal use of controlled substances?
- 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
- 24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

One Hilde RC

### · EMPLOYMENT CONTRACT

1, <u>Hone Hildreth</u> , ar (Applicant's Name)	n applicant for
Certification as a Physician's Assistant, am employed by	·
Planned Parenthosa of No. New Er (Employer's Name)	gland_
for the period beginning (Month/Day/Year)	
Termination of my contract will cause my Certification to become	ome null and void.
O On Le Hill Own PAC Signature of Physician's Assistant	11/27/00 (Date)
Signature of Supervising Physician	11/2 Ηδυ (Date)
Print Name of Physician:	

NOTE: A contract from each separate employer is required.

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VT 05609-1106 (802) 828-2673

DEC - 4 2000

### PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incompl	lete applications will be re	eturned. Attach additio	nal sheets as n	eeded.	TO STATE OF THE ST	2°45 от а развирот на д
Name in full	Gibson	<u>Chen</u>	3	(Middle)		
Mailing Address	Planned Pa	arenthood Office Name)			•	•
	as manst	rield AM.				
	Quella day	Street)	0130	mal		
(City/State)	THE WALL OF Y	<u>/                                    </u>	(Telephone	Number)		
Vermont License Num	nber: <u>042-000746</u> 5 Nu	ımber of years you hav	ve been practicí	ng medicine:	_	
Hospital(s) where you		Hospital(s) Loc		Specialty	<b>-</b>	
FAHC	Burl	artou, ut.		oblain		
-		J .		Contract of the Contract of th	мари	
List all physician's ass	sistants names and addre	esses you currently sur	pervise;		<u> </u>	
Any Gorgmo	in - Barre P.F	>				
August Bum	s - Hydelan	< 9.9				
Six Burton	J-Birl P.P	' (6	WER Pla	1900)	<del></del>	
What arrangements ha	ave you made for supervi	ision when you are no	t available or ou	t of town:		
24 hour	on-call Si	Hem		·····	_	
	CERTIFICATE	OF SUPERVISI	NG PHYSIC	IΔN	_	
I hereby certify that, in	accordance with 26 VSA				activities of	
the protocol outlining t	he scope of practice, atta fiy that notice will be post 741.	ached to this applicatio	on, does not exc	eed the normal limit	s of my	
further certify that I ha	ave read the statutes and	d Board rules governin	g physician's as	ssistants.		
11/27/00		X		lelen		
(Date)			(Signature of	Supervising Physic	ran) PA	
Note: A PA who prescr	Co ribes controlled drugs mu	o-signature of PA: \_ ust obtain an ID numbe	<u>メ(ハヘど)し</u> er from DEA.P	<u>ひついし</u> 'A's DEA Number: ハ	<b>后</b>	,

### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

109 STATE STREET MONTPELIER, VT 05609-1106 (802) 828-2673 DEC - 4 2000

VERSON STATE OF

### SECONDARY SUPERVISING PHYSICIAN APPLICATION

r lease philit. Incomplete ap	plications will be ret	umed. Attach at	iditional sneets	as needed.	
Name in fullSp	2134	Susar	)		
(	Last)	(First)		(Middle)	_
Mailing Address	Hanned K	DONN BY	d		
	(Of	fice Name)			
an.	anom Ess	Held A	e.		
	(St	reet)			
	ANCUT.	027/01	863-	9001	
(City/State)	(Zi <sub>f</sub>	Code)	(Teleph	one Number)	<del></del>
Vermont License Number:	42-0005990Num	nber of years yo	u have been pra	acticing medicine:	
Hospital(s) where you have	privileges	_ Hospital(s	) Location	Special	ty
4AHC	Furling	TV, UMA		(P)(a	
The state of the s		)			<del>}</del>
					<u> </u>
List all physician's assistants	names and addres	ses you current	y supervise:		
Amy Gorama	n- Bane	4.6			
August Cums	- Hyde	Par P.	?	····	
Sir Gurton	- Burl	60	OPL		
CERTIFI	CATE OF SEC	ONDARY S	UPERVISIN	IG PHYSICIA	N
I hereby certify that, in accor					
Anne Sanuer	HILDREN	, P.	A, only when the	e nrimary supervisi	ing physician is
unavaliable and only when c	onsulted by the afor	esaid Physician	's Assistant. I fi	urther certify that tl	he protocol
outlining the scope of practic in accordance with 26 VSA,	e, attached to this a Chapter 31, Section	pplication, does 1741, the use o	not exceed the f a physician's a	normal limits of massistant has been	y practice and tha i posted.
I further certify that I have re	ad the statutes and	Board rules gov	erning physiciar	n's assistants.	
			$\subset$	. X.	
			$\cap \cap$	M KON/XI	late
(Date)		(c	Signature of Sec	condary Supervisir	ng Physician)

01/08/02 TUE 15:04 FAX 802 828 5450

VT.Medical Board

Return Directly to Board

Reference Form #1 STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET

MONTPELIER, VERMONT 05609-1106 (802) 828-2673

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY, PAGE ONE OF TWO

Name of Applicant: 1700 The physician's assistant named about practice as a physician's assistant in knowledge through recent observation work cooperatively with others. In this cooperation.	Vermont. The n of the applic.	to the Vermont Bo applicant has liste	d your name as one i al competence, ethica	who has requisite to the character, and ability to
Please complete all parts of this form	. If more room	i is needed, please	attach additional info	ormation.
Name Anne Hildret	<u> </u>	was at	<u>Planned Ke</u>	areuthood
from 3/9/94	to()	resent	During the	t time, he/she
was (List status in the Institution):	dust	dan Ass	sistant_	
IMPORTANT NOTE: If you rate the a of the reference in as much detail as	ppilicant "poor possible.	or fair in a parti	cular category, pleas THNGS ONES	attackory, equivalent is
The basic medical knowledge to be expected in a P.A.	Poor	Fair	Average	Above Average OVETORGE - TO
Professional judgment:	Poor	Fair	Average	_Above Average above average
Sense of Responsibility:	Pacr	Fair	Average	Above Average
Moral character/ ethical conduct:	Paor	Falr	Average	Above Average
Competence and skills in the tasks delegated:	Poor	Fair	Average _	Above Average
Cooperativeness, ability to work with others	Poor	Fair	Average	Above Average
Willingness to accept directions and limitations in role:	Poor	Fair	Average	Above Average
History & physical exam taking:	Poor	Fair	Ayaraga .	Above Average
Record keeping:	Poor	Fair	Average	Above Average
Patient management:	Poor	Fair	Average	Above Average
P.APatient relationship:	Poor	Feir	Average	Above Average
Track record in adhering to scope of practice:	Poor	Fair	Average	Above Average
Ability to communicate in reading, writing & speaking the English langu	age: Poc	rFair	Average	Abové Average

01/08/02 TUE 15:05 FAX 802 828 5450

VI. Medical Board

Continued

### Reference Form #1 STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106

(802) 828-2673

# REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY PAGE TWO OF TWO

FACE INC.	
Name of Applicant: Anne Hildreth	@
To the best of your knowledge, does/did the applicant carry out the duties and responsibili- institution in a satisfactory manner?	ies of the position at you  O Yes No
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug impair the applicant's ability to practice as a physician's assistant?	problem, which might YesNo
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	Yes <u></u>
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses?	Yes Yes No
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	Yes P No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	Yes P No
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	Yes V No
Do you know of a fallure of the applicant to complete a training program(s)?	Yes <u>V</u> No
Does the applicant call upon consults when needed?	<u> </u>
In addition to the information provided on the previous page, please use the space below a elaboration on the above and any additional information you have available to aid the Boa applicant. Of particular value to us in evaluating any candidate are comments regarding hand/or weaknesses. We would appreciate such comments from you. Any additional information this form.	rd in evaluating this is/her notable strengths
The above report is based on:	
Close personal observation	
General impression	
A composite of previous evaluations Other - Specify: CLANCOL EVALUATIONS	
I further certify that at the time of completion of the above training, or during my association	n with the physician's
assistant, he/she was competent to practice as a physician's assistant and he/she was no	t the subject of any
disciplinary action,	
I recommend ANDR HILDRETH for licensure in Vermont	
Name of Physician's Assistant	
Signed: Date: 1/17/0	<u> </u>
about Citeon mo	
Print or Type Name and Title: CNETUL 6165011.	<del></del>

01/08/02 THE 15:05 FAX 802 828 5450 VT. Medical Board

Return Directly to Board

Reference Form #2 . . . STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY PAGE ONE OF TWO  $\cap$ 

Name of Applicant:  The physician's assistant named practice medicine in Vermont. Trecent observation of the applications are the applications of the applications of the applications are the applications.	l above has applied he applicant has lis ant's current clinical	to the Vermont I led your name a competence, eth	s one who has requisit rical character, and ab	e knowledge through lifty to work cooperatively	Y
with others. In this regard, please Please complete all parts of this Name:			se attach additional inf		
from <u>319194</u>	Physicia	resent	During that	at time, he/she was	
(List status in the Institution):	the applicant "poor"	or "fair" in a par	ticular category, pleas	e elaborage on this asper	
The basic medical knowledge to be expected in a P.A.	Poor	Fair	Average _	Above Average	to average
Professional judgment:	Poor	Fair	Average	Above Average	apor arevo
Sense of Responsibility:	Poor	Fair	Average	Above Average	And the second s
Moral character/ ethical conduct:	Poor	Fáir	Average	Above Average	
Competence and skills in the tasks delegated:	Poor	Fair	Average	Above Average	
Cooperativeness, ability to work with others	Poor	Fair	Average	Abova Average	
Willingness to accept directions limitations in role:	and Poor	Fair	Average	Above Average	
History & physical exam taking:	Poor	Fair	Average	Above Average	
Record keeping:	Poor	Fair	Average .	Above Average	
Patient management:	Poor	Fair	Average	Above Average	
P.APatient relationship:	Poor	Fair	Average	Above Average	
Track record in adhering to scope of practice:	Pocr	Fair	Average	Above Average	
Ability to communicate in reading writing & speaking the English is		EFair	Average	Above Average	

01/08/02 TUE 15:05 FAX 802 828 5450 VT. Medical Board

Reference Form #2 Continued

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET

MONTPELIER, VERMONT 05609-1106 (802) 828-2673

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY
PAGE TWO OF TWO

Name of Applicant: Hone Hildleth
To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?
Do you know of any emotional disturbance, mental lilness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a physician's assistant?
Do you know of any pending professional misconduct proceedings or medical malpractice
Do you know if the applicant has been a defendant in any criminal proceeding other thanYes
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?  Yes   No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?  Yes   No
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?Yes
Do you know of a failure of the applicant to complete a residency training program(s)? Yes X No
Does the applicant call upon consults when needed? YesNo
In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strangths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attache to this form.
The above report is based on:  Close personal observation  General impression  A composite of previous evaluations  Other - Specify: Climical Evaluations
I further certify that at the time of completion of the above training, or during my association with the physician's assistant, he/she was competent to practice as a physician's assistant and he/she was not the subject of any disciplinary action.
I recommend AME HILLSET for licensure in Vermont.
Signed: Name of Physiciants Assistant Date: 1/5/02
Print or Type Name and Title: SUSAN SMITH



December 21, 2001

Vermont Board of Medical Practice 109 State Street Montpelier, VT 05609

RE: Anne Sarver Hildreth, PA-C

To Whom It May Concern:

Anne Sarver Hildreth is currently certified by the NCCPA and holds certificate no.1011311.

Initial certification was granted on January 15, 1983. Anne Sarver Hildreth will remain certified by NCCPA until December 31, 2003.

If you have any questions regarding the information provided in this report, please contact us at the number below. To receive information about NCCPA's certification requirements and policies via our free fax on demand service, call 770.734.4500, select option 6 from the main menu and request document # 101, Certification Maintenance Guidelines. Or visit our web site, www.nccpa.net.

Sincerely,

Ragan Morrow,

Director of Certification Maintenance

DEC 26 2001

VERMONT BOARD OF NEDICAL PRACTICE

The official NCCPA seal is affixed above on the original of this document.

Orexel

College of Nursing and Health Professions Physician Assistant Program Advanced Physician Assistant Studies Program

Mail Stop 504 • 245 N. 15th Street • Philadelphia, PA 19102-1192 TEL 215.762.7135 • FAX 215.762.1164

www.mcphu.edu

03 January 2002

State of Vermont Board of Medical Practice 109 State Street Montpelier, VT 05609-1106 JAN 7 2002 W

IN RE: ANNE HILDRETH, PA-C

To whom it may concern:

This letter serves to verify that Ms. Anne Hildreth matriculated into the MCP Hahnemann University Physician Assistant Program on September 2, 1980. She successfully completed the program o June 10, 1982.

If further information is desire, please do not hesitate to contact me.

Sincerely,

Patrick C. Auth, Ph-C, MS, PA-C Assistant Professor and Director Physician Assistant Program



#### Commonwealth of Massachusetts

#### Division of Professional Licensure

(Formerly Division of Registration)
239 Causeway Street • Boston, Massachusetts 02114

JANE SWIFT GOVERNOR

JENNIFER DAVIS CAREY
OFFICE OF CONSUMER AFFAIRS

WILLIAM G. WOOD

# Board of Registration of Physician Assistants phone # (617) 727-3069

Certified Statement of Registration

December 28, 2001

The individual named below is in good standing in the Commonwealth of Massachusetts as a licensed *Physician Assistant* 

Name: Anne S. Hildreth

License No.: 574

Original Issue Date: January 4, 1994

Expiration Date: March 1, 1995

Gladys M. Clifton

Board Administrator

Board of Registration of Physician Assistants

SEAL

#### Registration verification can be obtained over the Internet: www.state.ma.us/reg/boards/ap

The information provided in this "Certified Statement" is based on the records maintained by the Massachusetts Division of Professional Licensure and its licensing boards. Individuals are deemed to be in good standing if their license is current and not subject to any disciplinary status on the date of issuance of the "Certified Statement." Disciplinary status is defined as voluntary surrender, revocation, suspension, or probation of a license.



### State of New Hampshire

2 Industrial Park Drive, Suite 8

Concord, NH 03301-8520

(603) 271-6936





This is to certify that the records of the New Hampshire Board indicate the following information:

Licensee: ANNE S HILDRETH

Specialty: PA P.

PHYSICIAN ASSISTANT

License Number: 0084

Issue Date: 10/24/83

Expiration Date: 12/31/02

Disciplinary Action: NONE

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by this Board.

Secretary

01-10-02

Date

SEAL

### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE-PAGE SEVEN OF SEVEN SECTION IV

#### 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)

un um oub	
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 <u>NOT</u> 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
standing w	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 vith 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 oner 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:
<u>×</u>	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 <u>NOT</u> 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
to, or ente declaration payments i payments i contributio	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) er 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 in, 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 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 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 are 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 ring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.
3.	$You\ \underline{must}\ check\ one\ of\ the\ three\ statements\ below\ regarding\ unemployment\ contributions\ or\ payments\ in\ lieu\ of\ unemployment\ contributions:$
·	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.)
	I hereby certify that I am <u>NOT</u> 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.
_<_	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 Se	ecurity #*  Date of Birth
Departm	sclosure 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 nent of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such d 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 Applican Inco Hildren Date 12/4/00

## PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's <u>Scope of Practice</u> for Physician's Assistants consists of several documents:

- 1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.
- 2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.
- 3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.
- 4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

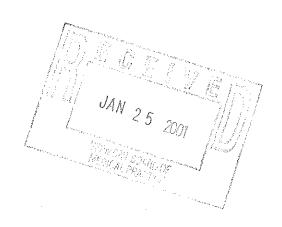
As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is

required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

PPNNE's P.A. Practitioners do not independently prescribe or dispense controlled substances and therefore, do not have DEA numbers.

### State of New Hampshire

2 Industrial Park Drive, Suite 8 Concord, NH 03301-8520 (603) 271-6936



### **Verification Report**

This is to certify that the records of the New Hampshire Board indicate the following information:

Licensee: ANNE S HILDRETH

Specialty: PA PHYSICIAN ASSISTANT

License Number: 0084

Issue Date: 10/24/1983

Expiration Date: 12/31/2001

Disciplinary Action: NONE

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by this Board.

Secretary

Date

SEAL

#### STATE OF VERMONT, BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

### CERTIFICATE OF PHYSICIAN'S ASSISTANT EDUCATION

To be completed by an officer of your University

I hereby certify thatAnne S-ARURE H I (Name)	LORETH was admitted to the
Hahnemann University (presently MC	P Hahnemann University) Physician's Assistan
01 1 0	on
Sept. 2, 1980	
(Date)	
and completed all requirements for graduation onJ	une 10, 1982 (Date)
APhysician Assistant certificate	_ was granted of une 10, 1982
(Specify certificate/diploma/degree)	(Date)
Is this program CAHEA or successor agency approved?	XXX YesNo
	(AFFIX SEAL)
Date: 12 December 2000	
Signed: (Authorized Officer of the School) Patrick C. Auth, MS, PA-C, Program Directo	r

TO PROGRAM: Return to above address

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

#### LIST OF TWO REFERENCES

The Board rules require that references be from allopathic or osteopathic physicians with whom the applicant has worked recently, including one from the most recent primary supervisor. If the applicant has recently graduated from a Board-approved physician's assistant program, one must be from the Director of the program. If the applicant has recently completed a Board-approved apprenticeship program, one must be from the primary training physician.

Detach the attached Reference Forms and send to the individuals designated below ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

Names, addresses and telephone numbers of two references:

1) Reference #1 - Name of a Physician: Do Jude 14500
Address:_
City, State
Telephone
How long has this individual known you?
2) Reference #2 - Name of Physician:
Address: <u>Clo Womens Choice - PPNDE</u>
a3 Mansfield, Aug-
City, State, Zip Code: Bullington, UT. 05401
Telephone: (802) · 863 · 9001
How long has this individual known you?

FORM B

TO WHOM IT MAY CONCERN:

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE **109 STATE STREET** MONTPELIER, VERMONT 05609-1106 (802) 828-2673

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF YOUR APPLICATION

1) I, 11/10 SQ Uen HI (Does), HEREBY AUTHORIZE YOU to furnish to (Name of Applicant)
the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice as a physician's assistant, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.
Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.
YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.
A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.
2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for certification.  Signature:
Date: 1214100
Print or Type Name: ANNS HILDRSTN
Address:City, State
Telephone
Subscribed and sworn to before me, this 12 day of Documber.
Notary Public
A CONFORMED COPY, ATTEST Wenn Welen-Register
Notary Public RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION SEND COPIES WITH THE REFERENCE FORMS

Reference Form #1 Return Directly to Board

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE **109 STATE STREET** MONTPELIER, VERMONT 05609-1106

(802) 828-2673

FEB

VERBOAT SOATE OF MEDICAL PRACTICE

# REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY, PAGE ONE OF TWO

The physician's assistant named practice as a physician's assistant knowledge through recent observ work cooperatively with others. In cooperation.	t in Vermont. The	e applicant has li	sted your name as o	ne who has requisite
Please complete all parts of this for	orm. If more roon	n is needed, plea	se attach additional	information.
Name Anne Hidre	4	was at _	<u> </u>	
from	to	<u>theles</u>	During	that time, he/she
was (List status in the Institution):	NH \6	b b	<u>árenthaid</u>	
IMPORTANT NOTE: If you rate the of the reference in as much detail	e applicant "poor as possible.	" or "fair" in a pa	irticular category, ple	ase elaborate on this aspect
The basic medical knowledge to be expected in a P.A.	Poor	Fair	Average	Above Average
Professional judgment:	Poor	Fair	Average	Above Average
Sense of Responsibility:	Poor	Fair	Average	Above Average
Moral character/ ethical conduct:	Poor	Fair	Average	Above Average
Competence and skills in the tasks delegated:	Poor	Fair	Average	Above Average
Cooperativeness, ability to work with others	Poor	Fair	Average	Above Average
Willingness to accept directions an limitations in role:	d Poor	Fair	Average	Above Average
History & physical exam taking:	Poor	Fair	Average	Above Average
Record keeping:	Poor	Fair	Average	Above Average
Patient management:	Poor	Fair	Average	Above Average
P.APatient relationship:	Poor	Fair	Average	Above Average
Track record in adhering to scope of practice:	Poor	Fair	Average	Above Average
Ability to communicate in reading, writing & speaking the English lang	uage: Poor	Fair	Average	Above Average

Reference Form #1
Continued

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

# REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY PAGE TWO OF TWO

Name of Applicant: 400e Hildreth		
To the best of your knowledge, does/did the applicant carry out the duties and responsible institution in a satisfactory manner?	lities of the	position at your
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug impair the applicant's ability to practice as a physician's assistant?	problem,	which might s No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	e Ye:	s No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses?	Ye:	s to No
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduc or malpractice?		s <u>i</u> No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	Yes	s _L_No
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	Yes	s <u> </u>
Do you know of a failure of the applicant to complete a training program(s)?		No No
Does the applicant call upon consults when needed?	<u>\</u> Ye:	s No
In addition to the information provided on the previous page, please use the space below a elaboration on the above and any additional information you have available to aid the Boa applicant. Of particular value to us in evaluating any candidate are comments regarding hand/or weaknesses. We would appreciate such comments from you. Any additional information to this form.	rd in evalu: is/her nota	ating this ble strengths
The above report is based on:  Close personal observation  General impression  A composite of previous evaluations  Other - Specify:  further certify that at the time of completion of the above training, or during my association assistant, he/she was competent to practice as a physician's assistant and he/she was not disciplinary action.	n with the p	ohysician's ct of any
recommend — The Hill Common for licensure in Vermont.  Name of Physician's Assistant  Date: 1/15/07		
Print or Type Name and Title: Chery 616800		

Reference Form #2 Return Directly to Board

### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET

MONTPELIER, VERMONT 05609-1106 (802) 828-2673

DEC 19 2000

# REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY BOARD OF PAGE ONE OF TWO

Name of Applicant: The physician's assistant named practice medicine in Vermont. The recent observation of the applicant with others. In this regard, please	above has appli ne applicant has nt's current clinic	listed your name a al competence, eth	s one who has requi	site knowledge through	
Please complete all parts of this f	<b>\</b> ; \	m is needed, pleas	se attach additional i	information.	n .d
	dreth_	was at _	Now EL	venthood of 1	vorthen
from April 89	to <u>v</u>	vesent		hat time, he/she was	
(List status in the Institution):	z physi	clan As	Elstant	<u> </u>	
IMPORTANT NOTE: If you rate the of the reference in as much detail	e applicant "poc as possible.	or" or "fair" in a part	icular category, plea	se elaborate on this asp	ect
The basic medical knowledge to be expected in a P.A.	Poor	Fair	Average	Above Average	
Professional judgment:	Poor	Fair	Average	Above Average	
Sense of Responsibility:	Poor	Fair	Average	Above Average	
Moral character/ ethical conduct:	Poor	Fair	Average	_iAbove Average	
Competence and skills in the tasks delegated:	Poor	Fair	Average	1 Above Average	
Cooperativeness, ability to work with others	Poor	Fair	Average	Above Average	
Willingness to accept directions ar limitations in role:	d Poor	Fair	Average	Above Average	
History & physical exam taking:	Poor	Fair	Average	Above Average	
Record keeping:	Poor	Fair	Average	Above Average	
Patient management:	Poor	Fair	Average	Above Average	
P.APatient relationship:	Poor	Fair	Average	Above Average	
Track record in adhering to scope of practice:	Poor	Fair	Average	Above Average	
Ability to communicate in reading, writing & speaking the English lang	uage: Poo	rFair	Average	Above Average	

Reference Form #2 Continued

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET

#### MONTPELIER, VERMONT 05609-1106 (802) 828-2673

# REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY PAGE TWO OF TWO

Name of Applicant: Aune Hildreth
To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a physician's assistant?  Yes
Do you know of any pending professional misconduct proceedings or medical malpractice claims?  YesNo
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses?  Yes Ves
Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?  Yes
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?  YesNo
Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?YesNo
Do you know of a failure of the applicant to complete a residency training program(s)?YesNo
Does the applicant call upon consults when needed?Yes No
In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.
The above report is based on:  Close personal observation  General impression  A composite of previous evaluations  Other - Specify:
further certify that at the time of completion of the above training, or during my association with the physician's assistant, he/she was competent to practice as a physician's assistant and he/she was not the subject of any disciplinary action.
recommend Aux Holdeth for licensure in Vermont.  Name of Physician's Assistant
Signed:
Print or Type Name and Title: Judith Tyson, M.D.
Medical Director (retired 7/31/2000)
Print or Type Name and Title: Judith Tyson, M.D.  Medical Director (retired 7/31/2000)  Planned Parputhood of Northern New England

FORM B

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF YOUR APPLICATION

# 1) I, Anne of Applicant) TO WHOM IT MAY CONCERN: (Name of Applicant), HEREBY AUTHORIZE YOU to furnish to

the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice as a physician's assistant, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

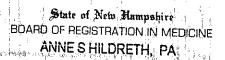
YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

Signature: One Hilds PAC
Date: 12 4 00
Print or Type Name: ANNE HICDRETM
Address:
City, State, Zip Code
Telephone Number:
Subscribed and sworn to before me, this day of day of
Legna Wilson-leynolds
Notary Public
A CONFORMED COPY, ATTEST Clama Wan-legald
Notary Public RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

tenens companies regarding the status of my application for certification.



License #: 0084 P

Issued: 10/24/1983

is entitled to practice for the year ending 12/31/2001

## NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

Anne Sarver Hildreth

has successfully completed all requirements to achieve or maintain NCCPA certification

Certificate Number: 1014311
Expiration Date: June 1/2061
This card is for identification purposes only and does not constitute proof of certification. For verification, please contact NCCPA.

FORM B

TO WHOM IT MAY CONCERN:

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE **109 STATE STREET** MONTPELIER, VERMONT 05609-1106 (802) 828-2673



THEREBY AUTHORIZE YOU to furnish to

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF YOUR APPLICATION

(Name of Applicant)
the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice as a physician's assistant, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.
Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.
YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.
A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.
2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for certification.
Signature: Unce thild
Date: 1214/00
Print or Type Name: ANNS HILDRETH  Address:
City, State, Zip Cog
Telephone Number
Subscribed and sworn to before me, this 12 day of Documber.
Liana Ullan-Neyrdd Notary Public
A CONFORMED COPY, ATTEST Chan Wilm-Register
Notary Public RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION SEND COPIES WITH THE REFERENCE FORMS

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VERMONT 05609-1106 (802) 828-2673

## APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT INSTRUCTIONS AND CHECKLIST, PAGE ONE OF TWO

		THE STEERLEST, I AGE ONE OF TWO
S		Thank you for your interest in physician's assistant (PA) certification in Vermont.  Enclosed please find the application for certification. If you require an application status update, please telephone the office. It takes a minimum of six weeks to complete the process if there is nothing in the application requiring further Board review.  Any applicant with a disability who needs an accommodation should contact the Board office. The following is a list of documents required (Unless noted, a copy of the original, if applicable—is required to be submitted):
(	1)	Fee of \$75. If initial PA certification (\$50 if not initial). Check made payable to the Vermont Board of Medical Practice.
1	2) -	Completed APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT IN VERMONT.
· ·	(3)	Certified copy of Birth Certificate.
	4)	Copy of your employment contract. We have enclosed an employment contract form should you wish to use it.
	anhei Ais	PRIMARY SUPERVISING PHYSICIAN APPLICATION must be completed by your primary sing physician and returned directly to this office. The Board may invite the supervising a to an interview if the Board has not previously reviewed the system of care delivery in which you propose see.
	6) V physician	SECONDARY SUPERVISING PHYSICIAN APPLICATION from any secondary supervising of secondary supervising
	complete	VERIFICATION OF PHYSICIAN'S ASSISTANT LICENSURE OR CERTIFICATION must be ged by the Licensing Board of each state where you now or have ever been allowed to practice as a n's assistant. Copies of certifications or licenses are not accepted.
	8)(	For University trained applicants:
+		A. A Certificate of Physician's Assistant Education must be completed by your University.
. ` `	12/4	B. Proof of satisfactorily completing the certification examination given by NCCPA (National Commission on the Certification of Physician's Assistants) from NCCPA To be sent directly to this office from the Examining Agency.
	9) <u>اینا</u> (9	or Vermont Apprenticeship trained applicants:
	 y	A, Documentation from the physician in charge of your Board-approved apprenticeship program that you have satisfactorily completed the program.
	An alternative property and an	B Submit final PA trainee evaluation conducted by the Board to ensure that you are qualified by ducation, training and experience to perform the duties outlined in your scope of practice.
	10)d	Scope of Practice (See attached definition): A detailed description of the duties and scope of practice elegated to you by your supervising physician including authority to prescribe medications.
	11)	Two (2) Completed Reference Forms mailed directly to the Board by the physician.



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE 183 Talcott Road, Suite 101 Williston, VT 05495-2075 Phone 802.878.7232 Fax 802.878.8001

March 5, 2001

Vermont Board of Medical Practice Attn: Janice Fifield 109 State Street Montpelier, VT 05609-1106

Dear Janice,

Enclosed you will find the primary and secondary supervising physician applications to attach to Anne Hildreth's Physician Assistants application, that was previously mailed to you.

Please call me at (802) 878-7716 x 241, if you have any questions.

Beverly Dion

Credentialing Coordinator

Enc.

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VT 05609-1106 (802) 828-2673

#### PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full	Sibson	Cher		many and an area and a company of the company of th	A	
Mailing Address	Planned	Parent Office Name	U(First)	d No	Middle B Well.	ingland
The state of the s	183 Taid	Street)	pad	- California de la companya de la c		
(City/State)	Williston	(Zip Code)	2480	(Telephone	Nember)	58
Vermont License Number:						
Hospital(s) where you have fletcher Allen		Hosp	Dital(s) Local	ion	obleyn	
List all physician's assistant Amy Borgman August Eurns Sue Burton Johanna Hauser What arrangements have y	- PP, Barre - P.P Hyde - P.P Burli - P.P Burli yau made tor super	Park naton magtin visio when y	Sarba Judy 1 Cate Katro	ira Nol Wedst Nickdo	ti - P.P er. P.P rs P.P	Burl. Williston
I hereby certify that, in according the separation of further certify the Chapter 31, Section 1741.	cope of practice, at	SA, Chapter 3	1. I shall be t P.A. while application.	legally respo : under my s   does not ex	nsible for all ri upervision. Ti seed the norm	urther cently that
I funher certify that I have r <b>2660)</b> (Date)		nd Board rules	X (	physician's a	ssistants.  Supervising	Physiciani C

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 109 STATE STREET MONTPELIER, VT 05609-1106 (802) 828-2673

#### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full Snth. (Last)	SUSAN (First)	(Middle)
Mailing Address Planned	Rarenthood (Office Name)	(Middle)
183 Ta	100HRD.	
(City/State)	(Zip Code) (Tei	2) 878 - 7232 ephone Number)
Vermont License Number 042005970 A	· ·	
Hospital(s) where you have privileges  Hetcher Allen  2	Hospital(s) Location Burlington, VT	Specially OBIGN
List all physician's assistants names and add  Amy Borgman P.P.  August Euros P.P.	Barre	
Sue Burton P.P	BURINGON	(Over)
CERTIFICATE OF Site of the score of practice, attached to the accordance with 26 VSA, Chapter 31, Secondaria of the score	P.A. only whe aforesaid Physician's Assistant ils application, does not exceed	ly responsible for all medical activities of n the primary supervising physician is I further certify that the protocol the normal limits of my practice and that
I further certify that I have read the statutes a	and Board rules governing phys	tcian's assistants
2/26/0/ ap	Jording S	Secondary Supervising Physician)



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE 183 Talcott Road, Suite 101 Williston, VT 05495 Phone 802.878.7232 Fax 802.878.8001

1/18/2002

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



To Whom It May Concern:

Enclosed you will find two completed references on Anne Hildreth, a PA affricated with Planned Parenthood of Northern New England. Please feel free to call me at (802) 878-7716 x 241, if you have any questions.

Sincerely,

Beverly Dion

Credentialing Coordinator

Enclosure

Mailing Address: 109 State Street

Montpelier, VT 05609-1106

Tel.: (802) 828-2673 Fax: (802) 828-5450



Office Location: One Prospect Street Montpelier, VT 05602

## State of Vermont Board of Medical Practice

TO: Cussie Silta
FROM: Chny
DATE: 2-14-02
RE: Anne Hildreth PA
Number of pages including cover sheet: 3
Message: (48518)
Here is the Scope for Ann.
She is mailing me the original
with the Signatures : & hope
you can do the interview
with this copy. If not let
ne know.
Jenn

This fax contains confidential information and is intended solely for the person to whom it is addressed. If this fax has been sent to you in error, please forward to the appropriate person or notify this office immediately at the phone number indicated above. Thank you.



FROM: 183 Talcott Road, Suite 10 Williston, VT 05495

Phone: (802) 878-7232 Fax: (802) 878-8001

To:

Phone:

Number of pages (including cover page): RE:

Scope of practice for

Anne Hildroff:

David A. Halbey, M.D. David L. Muller, M.D. Leonard M. Rudolf, M.D. Katherine A. Silta PA-C Sandeep B. Varma, M.D. Connecticut Valley Orthopaedics 2 & Sports Medicine, p.c.

#### ■ ORTHOPAEDIC MEDICINE

- Occupation al Injuries
- Arthritis Care
- Spine Care

## ■ ORTHOPAEDIC SURGERY

- Arthroscopy
- \* Arthroplasty
- Fracture Care
- Reconstructive Surgery

## SPORTS MEDICINE CENTER

- Education
- Prevention
- « Sports Injury Care
- Sport-Specific Training

F	A CSI	M	LE	COV	ER	SH	CET

DATE:	2/14/02	
NUMBER OF PA	GES (INCLUDING COVER SHEET) 2	
TO:	Denny Auser	
The second secon	B. O. M. P.	
		-
FAX NUMBER:	(802) 828-545C	1
FROM:	SILTA	

ATTENTION: This message is intended only for the individual to whom it is addressed. It contains information that may be confidential under law. If you are not the intended recipient or agent responsible for delivering this message, do not read, copy or distribute this information. If you have received this message in error, please notify us immediately by phone and return the message to us by mail. Thank You.

Springfield, VT Office - Box 2003 \* 24 Plagewice Road \* Springfield - Verhiom 05/35 \* 802/285/4373 \* Pix 602/885/4375

Claremont, NH Office \* 748 Elm Subst \* Claremont, New Hampshire 03743 \* 603-542 5801 \* Fax 603/642/5833

Lebanon, NH Office \* 129C Maximiz State: \* Lebanon, New Hampshire, 03765 \* 603-448/6344 \* Fax 603/446/3405

VT Medical Soard



## PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE at Planned Parenthood of Northern New England

Planned Perenthood of Northern New England's <u>Scope of Practice</u> for Physician's Assistants consists of several documents:

PPINE Standing Orders: Each P.A. precitioner annually signs the Standing Orders that are approved by PPNIVE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNIVE.

PINNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

Medical Oversight at PPNNE. Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of PIA silest PPNNE.

PPNNE.

4) Additional information about PPNNE's health centers, patient population and E.A. practice at Flanned Farenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless to a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are techniques and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

As specified in Section I, Part ! of the PPINIE | <u>Medical Protocol</u>, each clinic site is

see P.Z

VT Medical Board

**2**003

required to inform patients how to obtain gare in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

PFNNE's P.A. Practitioners do not independently prescribe or dispense controlled substances and therefore, do not have DEA numbers.

/# 1890 \$5000 Planne



IAN 0.2 2002 PARTIES EVED

SERVING MAINE

241 Elm Street Claremont, NH 03743 603.542.4568 HI BOARD OF MEDICINE

1/08/02

Please pond verification

Ong cernent license ?

The State of WH. to

The VT. Board of modicine—

Thentyou!

Sincerely-Anno Hildrah Pac Licersott 0084

L 12. THIRD CLASS MAIL \$115.00	5.00 5.00					
Mail this order form along with full payment to:  Joseph W. Mayo, Clerk of the House  2 State House Station  Augusta, Maine 04333-0002  Checks should be made payable to Treasurer, State of Maine.  IF YOU HAVE ANY QUESTIONS REGARDING DOCUMENT SERVICE  PLEASE CALL CHRIS WORMELL AT (207) 287-1400.						
MAILING ADDRESS (Please print name of person or company receiving documents) NEW NAME: KIM CRICHTON COMPANY: PLANNED PHRENTHOO ADDRESS: 367 US RENTE ONE (STREET)  FRAMNTH ME 04105 781-2201. (CITY) (STATE) (ZIP CODE) (TEL. NO.)	ENVER D					

\_Tel. No. \_\_\_\_

Name: \_

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2004-2006 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

I hereby apply for the **RENEWAL** of my **CERTIFICATION AS A PHYSICIAN ASSISTANT** for the period from 02/01/04 to 01/31/06.

- When space is insufficient, attach additional sheets.Make a copy of this form and all attachments for your own records.
- · Do not delegate this important task, as false statements on this form are grounds for findings of unprofessional conduct.
- Be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.
  - Please return the document in its entirely at your earliest convenience. Your current certificate expires on January 30, 2004.

PART I Name: Anne Sarver Hildreth Gender: 

Male 

Female 28 3. Vermont Certification Number: 055-0030584 VERMONT BOARD OF 4. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere corrections 5. Home Address: City, State, Zip C 6. Work Address: 89 S. MAND ST LO. LEBGOOD, DH037 82 Please check your preferred mailing address: 

Home (This address will be public and listed on the Board's website) 7. Email Address 8. Daytime Telephone Number: Area Code: (603) 298,7766 9. Date of Birth (Month/Day/Year): 10. Place of Birth:

11. Certification Examination Taken – (Check box and enter date of examination):
NCCAA gloups.
State Examination-Identity by state:
Other Examination specify:
12. Basis for Vermont Certification – (Check box):
日 Apprenticeship Trained University Trained
13. Do you have hospital privileges in Vermont? ☐ Yes ☑ No
Hospital Name(s) and Location(s):
14. In what year did you start working as a physician assistant in Vernont?
15. Did you practice in Vermont during the past 12 months? Si Yes No
An applicant for certification renewal who has not practiced as a Physician Assistant for more than twelve months must submit a satisfactory evaluation by the Supervising Physician.
16. Other states where you now hold an active certification or license to practice: N. H.
17. States where you previously were certified or licensed to practice:
18. Specialty: OB Gyn DEA Number: MHO195986
19. Name and office address of current EMPLOYER:
Name Address
PPNDE 895. MAINST, W. Lebonon, R
20. Please indicate the total number and list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).
Total number 3
Primary Supervising Physician(s):
Name: Cheryl A. Gibson Address: 23 Mansfield Avenue
Burlington, VT 5401
Name Address

Secondary Supervising Physician(s):	
Name Suscio Smit 23 Mansfield Ave;	Burl. VI
Kym Boyman -	
21. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising pl review the most current scope of practice for your practice setting, paying attention to any additional duties and procedures. Please review, date and sign your scope of practice and have your PRIMAL SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to the	s or deletions in
a. Has there been a change in your scope of practice which has not been reviewed by the Board?	□ Yes 🛛 No
22. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced Assistant within the past twelve months.	as a Physician
23. Continuing Medical Education (CME) requirements:	
a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will se proof of CME completion.	rve as adequate
b. For all others, an explanation of requirements and a logging form must be completed.	
24. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be returned with this application.	e completed and
PART II	
"Yes" answers to Questions 25 - 39 require an explanation on Form A.	
Important note regarding the following questions: "Yes" answers on past renewals must be updated on I example, if a previously reported malpractice action has been dismissed, please indicate that on Form A	Form A. For
Any "yes" response to the questions below must be fully explained on Form A.	,
Certification and Practice Questions	
25. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art?	□ Yes 🖄o
26. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art?	□ Yes ⊠Ño
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?	□ Yes ♠ No
28. 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
29. Have you ever been denied the privilege of taking an examination before any state medical examining board?	☐ Yes ☐(No
30. 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
31. Have you ever been dismissed or suspended from, or asked to leave a residency training program	□ Yes 💆 No

32.	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 ØNo				
33.	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 ੴNo				
34.	Are you presently a defendant in a criminal proceeding?	□ Yes 🖾 No				
	PART III					
	Confidential Section (This section is exempt from public disclosure) Any "yes" response to the questions below must be fully explained on Form A.					
35.	To your knowledge, are you the subject of an investigation by any other licensing or certification authority as of the date of this application?					
36.	To your knowledge, are you presently the subject of criminal investigation?					

#### MEDICAL QUESTIONS

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

#### **DEFINITIONS**

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

- 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" - This term 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 certified professional.

"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.

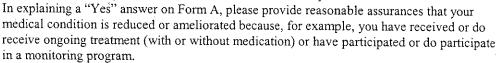
"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"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

Vermont Department of Health - Board of Medical Practice - 2004-2006 Physician Assistant Certification Renewal

care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

37. 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?



38. 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? 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.



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

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, board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

#### 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 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 or certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

40. 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)	(Court)	(City/State)	(Crime)

<ol> <li>Nolo Contendere/Matt</li> </ol>	ers 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.

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

#### 42. 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.

(Date)	(Final Disposition - Summary)
(Date)	(Final Disposition - Summary)
(Date)	(Final Disposition - Summary)

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

#### 44. 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 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)	(Hospital)	(State)	(Nature of Restriction)	(Reason for Restriction)
(Date)	(Hospital)	(State)	(Nature of Restriction)	(Reason for Restriction)

	Other Restricti	<u>ons</u>				
	the restriction of	of privileges at petence or char	t a hospital ta racter in that	tions from, or non-reaken in lieu of, or in shospital. Please pro	settlement of, a pen	ding disciplinary o
	(Date)			(Hospita	.1)	(State)
	(Nature of Acti	on)		(Action)		
	(Reason for Ac	ction)	· · · · · · · · · · · · · · · · · · ·	□ In lie	ı 🗆 In settl	ement
Medical M	alpractice Court J	udgments/Sett	<u>lements</u> [Se	e 26 VSA § 1368(a)(	(6A)]	
A. <u>Ju</u>	dgments					
	malpractice arb	itration award	s against you	l malpractice court ju i in which a payment cumenting these ma	was awarded to a c	ou and all medical complaining party
	☐ Judgement	□ Arbitrati	on			
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed	l Against You)
	☐ Judgement	□ Arbitrati	on	·		
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed	l Against You)
Β. <u>S</u> ε	ettlements					
	Please provide payment was av these matters.	a description of warded to a co	of all settlem mplaining pa	ents of medical malp arty. <b>Please provide</b>	ractice claims agair copies of papers f	ast you in which a ully documentin
	(Date)	(Court)	(State)	(Amoun	of Settlement Aga	inst You)

7.	granting pe	ents/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering ermission to have this information posted on the web. (This formation appointments, these questions may overlap.)	#35 is optional. By answering, you are n follows the statutory wording. Since most
	A.	Appointments	
		Please provide information about your appointments to medi	cal school or professional school faculties.
		Dashmout MS Noncie 10H (School) (City) (State) (Nature of App	
		(School) (City) (State) (Nature of App	pointment) From (year) To (year)
	В.	Teaching	
		Please provide information regarding your responsibility for within the past 10 years.	teaching graduate medical education
		(School/Institution) (City) (State) (Nature of	of Teaching) From (year) To (year)
	past 10	b. Please provide information regarding your publications in polyears.	
	(Title	(Publication)	(Year)
	(Titl	(Publication)	(Year)
9.	<u>Activit</u>	ties [See 26 VSA § 1368(a)(14)]	(,
-	Note: A	Answering #52 is optional. By answering, you are granting perr b. Please provide information regarding your professional or co	nission to have this information posted on ommunity service activities and awards.
	<del></del>	(Activities or Awards)	
	50. Pra	actice Setting [See 26 VSA § 1368(a)(15)]	
	What is	s the location of your primary practice setting?	
	Town/G	City, State	<u>.                                    </u>

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

Vermont Department of Health – Board of Medical Practice – 2004-2006 Physician Assistant Certification Renewal Page 8 of 11

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

		iny translating services available at your pi s, please describe the translating services a		location?   Yes   No
			······································	
	***************************************			
52.	<u>Medicaid</u>	New Patients [See 26 VSA § 1368(a)(17)		
	Α.	Medicaid participation  Do you participate in the Medicaid pro	gram?	S Yes □ No
	В.	New Medicaid Patients		
		Are you currently accepting new Medi	caid patients?	¥ Yes □ No
			Part V	
Are	you currer	atly active in clinical practice, in Vermont?		□ Yes No (housings)
If yo	ou do not p	rovide patient care in Vermont, skip the re	est of Part V and	d go to Part VI.
For	the practic	e location(s) in Vermont related to this cer	tificate, please	answer the questions below.
אוע	eci îau	ne specialty codes from the list provided (1 ENT CARE. Include both AMBULATOF clude on-call hours.	ink), and enter : RY care and HC	the average hours per week you spend providing OSPITAL care of patients who originate from this
Ente	er the Verm	nont town name for this location:		
(If y	ct the ONE ou provide inate.)	E practice setting that best describes this pre hospital care to patients who originate from	actice: om your office	or clinic, choose only the setting from which they
	Frospitateo School or ( Business o Extended (	y-Based practice (including associated hosased practice (Inpatient, Emergency Room College Health Center r Work Site Care / Nursing Home	spital care - solo n, etc)	o or group office, Community Health Center, etc.)
I wo	rk as a locı	ım tenens here □Yes □No		
If thi	s is an offi	ce-based practice, please answer the follow	wing:	
I cur I wil I wil I wil	rently have l accept ne l accept ne l accept ne	e patients here covered by Medicaid patients here covered by Medicare w patients here w Medicaid patients here w Medicaid patients here w Medicare patients here	□Yes □No □Yes □No □Yes □No □Yes □No □Yes □No	
Enter (48 v	r the numb veeks is co	er of weeks you spend providing direct pa nsidered to be "full time") [2 digits]	tient care here i	in a year:

Enter your specialty and the number of hours you spend providing direct patient average work week:	t care here under that specialty in an
First Specialty: [4 digits] (see attached list or link) Hours per week:	[2 digits]
Second Specialty: [4 digits] (see attached list or link) Hours per week	: [2 digits]
Do you plan to retire or reduce your patient care hours AT THIS SITE in the ne	ext 12 months?
If you work at another location or setting UNDER THE SAME CERTIFICATE you work only at one site under this certificate please stop here, leave Part V bl another site under a different certificate, please describe your work at that site is certificate, not here.)	ank, and skip to Part VI. (If you work at the renewal form for that other
Enter the Vermont town name for the second location:	
Select the ONE practice setting that best describes this practice: (If you provide hospital care to patients who originate from your office or clinic originate.)	c, choose only the setting from which they
<ul> <li>□ Community-Based practice (including associated hospital care - solo or gro</li> <li>□ Hospital-based practice (Inpatient, Emergency Room, etc)</li> <li>□ School or College Health Center</li> <li>□ Business or Work Site</li> <li>□ Extended Care / Nursing Home</li> <li>□ Other:</li> </ul>	up office, Community Health Center, etc.)
I work as a locum tenens here □Yes □No	
If this is an office-based practice, please answer the following:	
I currently have patients here covered by Medicaid  I currently have patients here covered by Medicare  I will accept new patients here  □ Yes □ No  I will accept new Medicaid patients here □ Yes □ No  I will accept new Medicare patients here □ Yes □ No	
Enter the number of weeks you spend providing direct patient care here in a yea (48 weeks is considered to be "full time") [2 digits]	r:
Enter your specialty and the number of hours you spend providing direct patient average work week:	care here under that specialty in an
First Specialty: [4 digits] (see attached list or link) Hours per week:	[2 digits]
Second Specialty: [4 digits] (see attached list or link) Hours per weeks	[2 digits]
Do you plan to retire or reduce your patient care hours AT THIS SITE in the ne	xt 12 months? □Yes □No
If you work at more than two locations UNDER THE SAME CERTIFICATE plbriefly, e.g., "same specialty and hours in additional towns: X and Y":	lease describe the additional site(s)

#### Part VI

Reminder - You must also complete the 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: 12/10/03

Applicant's Signature

Vermont Department of Health Board of Medical Practice P.O. Box 70, Burlington, VT 05402 January 13, 2004

Vermont Board of Nursing 109 State Street Montpelier, Vermont 05609-1106

To Whom It May Concern:

This is to verify that for the last twelve months, Anne Hildreth has practiced as a Physician's Assistant at Planned Parenthood of Northern New England.

Please feel free to direct any questions you may have to our Credentialing Coordinator, Beverly Dion, at (802) 878-7232.

Sincerely,

Cheryl Gibson

Medical Director

The National Commission on Certification of Physician Assistants affirms that

# Anne Sarver Hildreth

has successfully completed all requirements to achieve or maintain NCCPA certification.

Certificate Number: 1011311 President
Expiration Date: December 31, 2005
This card does not constitute proof of certification.
Please contact NCCPA for verification.

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

### PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete applications	will be returned. Attach	additional sheets as r	needed.
Name in full	Gibson	cheryl	1	$\triangle$
	(Last)	(First)	(1	Middle)
Mailing Address	Planned	Parenthood		
	23 Man	SHELD (Office Name)		
(0: 10	Burl, V	(Street)	863-6326	)
(City/State)	•	(Zip Code)	(Telephone Nun	ıber)
Vermont License #:	<u>912-000741</u>	05		
Hospital(s) where you	ou have privileges	Eurlington, V	S) Location S	pecialty 610
		14		
3411 OLI	zecongani Can zervi	apervising	Physicians	
	CERTIFICAT	E OF SUPERVISING	PHYSICIAN	•
outlining the scope of pr	actice, attached to thi	SA, Chapter 31, I shall be leg A. while under my supervisits application, does not exceed a physician's assistant is used	on. I further certify that the thing of my	ne protocol
I further certify that I ha		nd Board rules governing phy (Signature of Sup	1/l/lM	
	(	Co-signature of PA:	) re Ir WCC	
Note: A PA who prescrib	es controlled drugs r	must obtain an ID number fro	m DEA. PA's DEA Num	ber <u>MHON</u> 5986

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

## SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete application	s will be return	ned. Attach ad	ditional shee	ts as needed.
Name in full	Smith		Susan		
	(Last)		(First)		(Middle)
Mailing Address	Planned	1 Parent	nood		
	as Mar	<u>nsfield</u>	e Name) ANC ·		
	Burl,	T. OS	101	803-	632b
(City/State)	•	(Zip Code)		(Telephone	Number)
Vermont License #:	043-00025	190			
Hospital(s) where yo	ou have privilege	es:	Hospital(s) L	ocation	Specialty
F.A.H.C		Burlin	gton, v T	<b>b</b>	oslagn.
List all physician's a Amy Borgman - August Burns - Sue Burton - (	4.4 BARRE .	Johnno Ho	WSET-PPA	irlination!	Barb Nolfi - F Janet Young - P Anne Hildreth
CERT	IFICATE OF S	ECONDARY	SUPERVISI	NG PHYSIC	CIAN
I hereby certify that, in a of Anne Hidreh only when consulted by practice, attached to this VSA, Chapter 31, Section	the aforesaid Physic application, does no n 1741, the use of a	P.A. only when the ian's Assistant. I texceed the norm physician's assis	ne primary superverself further certify the mal limits of my person that has been post	ising physician at the protocol oractice and that ted.	is unavailable and
further certify that I have	ve read the statutes a	and Board rules g	overning physicia	in's assistants.	
(Date)		(Signature of	f Secondary Supe	ノフ rvising Physicia	an)
		`	-		•

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

## SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete applications	will be returned. Attach ac	iditional sheets	as needed.
Name in full	Boyman	Kum		m.
	(Last)	(First)		(Middle)
Mailing Address	Planned !	Parenthood		
	23 Mans	Field AVE.		
	Burlingt	on VT. 05401	863-6	03Zb
(City/State)	J (	(Zip Code)	(Telephone N	Vumber)
Vermont License #:	<u>042-0010</u> 59	77		
Hospital(s) where ye	ou have privileges:	: Hospital(s) L	ocation	Specialty
F.A.H.C		Burlington, v	1.	OB GUN.
HUM NOVEWAL	- Y.Y BARRE	nd addresses you currently s Johanna Hauser-P. Katra Kindar -P. N Cate Nicholas-P	Driving afort	BAKD NOHTI-P.P. Janet Young -P.F N Anne Hildreth -
	9	CONDARY SUPERVISI	$\mathcal{O}$	· .
only when consulted by practice, attached to this	the aforesaid Physician application, does not of	SA, Chapter 31, I shall be legally A. only when the primary superven's Assistant. I further certify the exceed the normal limits of my physician's assistant has been post	ising physician is at the protocol out	unavailable and
%	e read the statutes and	d Board rules governing physicia	ın's assistants.	
1/22/04	· ·	X 1650		
(Date)		(Signature of Secondary Super	rvising Physician)	

## PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's <u>Scope of Practice</u> for Physician's Assistants consists of several documents:

- 1] PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.
- PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's 21 Medical Protocol, a copy of which is on file with the Vermont Board of Medical
- 3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at
- Additional information about PPNNE's health centers, patient population and P.A. 4) practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization With fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our Commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is

#### Vermont Department of Health - Board of Medical Practice

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

Y	ou	must	SUEMBL	tzeup	ons	1, 2	t, 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 in nī

repayme	nt p	ider as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support payable under illability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a lian approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment rould impose an unreasonable hardship. (15 V.S.A. § 795)
1.	¥9	u <u>must</u> 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.
	a	I hereby certify that I am <u>NOT</u> 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".
Tiels no b	444	Regarding Yaxes
on appea	d, th	Requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the less 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 taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that ayment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	ydi W	I <u>must</u> 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 plant 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).
	Q	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".
pace wit employing contributi all contributi he liabilit payment	h ar g un ions outlo by fo plan	Regarding Unemployment Compensation Contributions 8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business located to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate my employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the lit 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 declaration is made. For the purposes of this section, a person is in good standing with respect to any and one or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) or any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions in lieu of contributions due and payable would impose an unreasonable hardship.
		must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment.
		I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compilance 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.)
(		I hereby certify that I am <u>NOT</u> 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.
9	<b></b>	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.
ocial Sec	urit	Date of Birth

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.

Vermont Department of Health - Board of Medical Practice

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

#### 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 ASSISTANT CERTIFICATION RENEWAL APPLICATION

XX.00

Certificate # 055-0030584	PARTI	
Name: Anne Sarver Hildreth	PA-C	
2. Other Name(s), if any, unde	r which you were certified or licensed in Vermont an	d elsewhere:
3. Home Address:		
	PPANAS	PPNOS
4. Work Address: <u>\$95 m</u>	HINST (	20 BOX 717
City, State, Zip Code: 🕠 🗸	(ebenon DHO3784)	Soundfield [
Please check your preferred m	nailing address: 承Home □ Work (This address will be public and listed on the Board	's website)
5. Email Address _		
6. Daytime Telephone Number	Area Code: ( <u>603</u> ) <u>340 - 15(66</u>	
7. Date of Birth: Month:		
8. Place of Birth:		
9. Certification Examination Tal	ken – (Check box and enter date of examination):	
· (/_/)	NCCPA	JAN 5 2000
· (//)	State Examination-Identify state:	· ·
· (//)	Other Examination specify: NCCFA	
10. Basis for Vermont Certificat	ion – (Check box):	
□ Apprenticeship Tra	ined	
11. Do you have hospital privile	ges in Vermont? ☐ Yes ☒ No	
Hospital Name(s) and Location(	(s):	
2. In what year did you start wo	orking as a physician assistant in Vermont?	

12. In what year did you start working as a physician assistant in Vermont?
13. Did you practice in Vermont during the past 12 months? ☐ Yes ☐ No
14. Other states where you now hold an active certification or license to practice:
none a
15. States where you previously were certified or licensed to practice:
washington, D.C. and Annadate VA.
16. Specialty: 67N. (6) DEA Number: MB0763234 (6)
17. Name and office address of current EMPLOYER:
Name Address Planned Parenthood 90 Washington St. Barrett. 05641
18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).
Primary Supervising Physician(s):
Name Address
Chery 1 Gibson 23 Mansfield AVE. BUM, VT. 05401 @
Secondary Supervising Physician(s):
Name Address
Susan smith as Mansfield Ave. Burly T. 054010
19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.
a. Has there been a change in your scope of practice which has not been reviewed by the Board? ☐ Yes ☑ No
20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as Vermont Department of Health – Board of Medical Practice – 2006-2008 Physician Assistant Certification Renewal Page 2 of 19

21. Continuing Medical Education (CME) requirements:

24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes pro
25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art lieu of disciplinary action?
□ yes ⊏xnoo
26. 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
27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes □⁄no
28. 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 ﷺ no
29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes □yrío
30. 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 agains you?
□ yes ਕ(no
31. 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 oxno
32. Are you presently or have you ever been a defendant in a criminal proceeding?
□ yes, ∰tno
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.
33. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
34. To your knowledge, are you presently the subject of a criminal investigation?
The following definitions are provided to assist you in answering questions 35 through 37.
"Ability to practice medicine" - This term includes: The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to lear and keep abreast of medical developments; and 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 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.

35. 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?

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.

36. 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?

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.

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

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, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

#### Part IV - Statutory Profile Questions

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 practitioner profile is located at the following website <a href="http://healthyvermonters.com/bmp/mbsearchform.shtml">http://healthyvermonters.com/bmp/mbsearchform.shtml</a>.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.

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 **Please provide complete copies of documentation for each matter.** 

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

Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

#### Part IV - Statutory Profile Questions

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doc	ase include photocopies cuments if your answers mot process your applica	to questions 38 throug	ing authority decision h 43 have changed sir	s, and any other relevant nce your last application. We
38.	Criminal Convictions [See	e 26 VSA § 1368(a)(1)]	∠ Check here if none ∠	e <b>9</b>
	or parking tickets) of w	ription of all crimes (felon hich you have been conv ation for each matter.	ies and misdemeanors; ricted within the past 10	this includes DUI but not speeding years Please provide complete
	(Conviction Date)	(Court)	(City/State)	(Crime)
39.	Nolo Contendere/Matters	Continued [See 26 VSA	§ 1368(a)(2)]	neck here if none 🕏
	or where sufficient fac	ts of guilt were found and	I the matter was continu	contendere" ("I will not contest it" led without a finding by a court o ntation for each matter.
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
<b>4</b> 0.	Vermont Board of Medical	Practice Matters [See 2	6 VSA § 1368(a)(3)]	Check here if none      ⇔
	Please provide a desc Board of Medical Prac appealed.	ription of all formal charg tice (including stipulation	es served, findings, cor s), and final disposition	nclusions, and orders of the of such matters by the courts, if
	(Date)	(Final	Disposition - Summary	)
	(Date)	(Final	Disposition - Summary	)
	(Date)	(Final	Disposition - Summary)	

(Date	mattei	Disposition)			se provide co	(Court)		(Nature of Ch	
(Data	of Final	Dioposition	/1::	O - L'E					
(Date )	UI FIIIdi I	Disposition)	(Licensin	g or Certifica	tion Authority)	(Court)	(City/State)	(Nature of Ch	arge)
42. Re	estriction	of Hospital	Privileges [	See 26 VSA §	1368(a)(5)]	20	Check here if	none 🚱	
	Revoc	ation/Involur	ntary Restrict	ions					
	were re official	elated to con of the hospit	npetence or or all after proce	character and edural due pro	on or involunta I were issued b ocess (opportur on for each ma	y the hosp nity for hea	oital's govern	ing body or an	y other
	(Date)	.(	Hospital)	(State)	(Nature of Re	estriction)	(Reason f	or Restriction)	
	(Date)	(	Hospital)	(State)	(Nature of Re	estriction)	(Reason f	or Restriction)	
	B.	Other Res	trictions	Check he	re if none <b></b> ₩				
	restrict	ion of privile; petence or c	ges at a hosp	ital taken in li	s from, or non- eu of, or in settl Please provid	ement of,	a pending dis	sciplinary case	related
	(Date)			(Но	spital)		(State)		·
		e of Action) on for Action		□ In lieu	(Action) □ In settle	ement		:	
43 Me	·			nts/Sattlaman	ts [See 26 VS	Λ & 1269/	a)/64)]		
	А.	Judgments		k here if non-		v 3 1200(	a)(0A)[		
	,				A and provide	a dagarint	ion of all mass	dia at us aluum sti	
		court judgn the past 10 complaining	nents agains years (10 ye g party if not	t you and all rears from pay listed below.	medical malpra ment date) in v Please provid possible, a co	ctice arbit which a pa le comple	ration award syment was a te copies of	s against you awarded to a f <b>documentat</b>	within

	□ Judgment	□ Arbitra	tion			
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Asses	sed Against You)
	□ Judgment	□ Arbitra	tion			
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Assess	sed Against You)
B.	Settlements		here if none	• <b>◊</b>		
	within the past complaining past	t 10 years (1 arty if not lis	i0 years from ted below. <b>Pi</b>	ements of medical ma payment date) in wh ease provide compl essible, a copy of the	ich a payment wa ete copies of do	s awarded to a cumentation.
	(Date)	(Court)	(State	) (Ar	mount of Settleme	ent Against You)
	(Date)	(Court)	(State	) (Ar	nount of Settleme	ent Against You)
ou are g	ranting permissio	n to have th	is informatior	2)] Note: Answering a posted on the web. (pointments, these que	This form follows	the statutory
A.	<u>Appointments</u>					
	Please provide faculties.	information	about your a	appointments to medi	cal school or prof	essional school
	(School) (Ci	ty)	(State) (Na	ature of Appointment)	From (year)	To (year)
	(School) (Cit	ty)	(State) (Na	ature of Appointment)	From (year)	To (year)
B.	Teaching					
B.		information in the past 1	regarding yo 0 years.	our responsibility for to	eaching graduate	medical

44.

45.

46.

Publications [See 26 VSA § 1368(a)(13)]

	(Title)	(Publication)	(Year)
	(Title)	(Publication)	(Year)
47.	Activities [See 26 VSA §	3 1368(a)(14)]	
	Note: Answering #50 is or posted on the web. Plear activities and awards.	optional. By answering, you are granting permissi se provide information regarding your profession	ion to have this information al or community service
		(Activities or Awards)	
48. <u>F</u>	ractice Setting [See 26 VS.	A § 1368(a)(15)]	
		our primary practice setting? TO Washington & Planner	d Parenthaco
	Town/City, State		
49. <u>T</u>	ranslating Services [See 26	6 VSA § 1368(a)(16)]	
	Please identify any transl Are any translating service	lating services available at your primary practice ces available at your primary practice location?	
		are are action by the product location;	□ Yes ☑∕No ੴ
		e translating services available:	□ Yes ☑∕No 🚱
			□ Yes ☑/No ੴ
			□ Yes ☑/No છ
50. <u>M</u>		e translating services available:	☐ Yes ☑/No છ
50. <u>M</u>	If yes, please describe th  ledicaid/New Patients [See A. Medicaid particip	e translating services available:	☐ Yes ☑ No છ

#### Vermont Department of Health - Board of Medical Practice

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

Υ	ou m	ust	answer	questions	1.	2.	and	3

Signature of Applicant

and all child support due under that order.

#### Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a træfor 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 onetwelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quagiudicial 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)

Thereby 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 amsubject to a support order and I am in full compliance with a plan to pay any

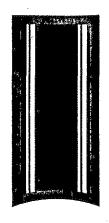
You must check one of the two statements below regarding child support regardless whether or not you have children:

		or
		I hereby certify that I am <u>NOT</u> 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
person c returns h	ertifi ave	3 requires that: A professional license or other athority to conduct a trade or business may not be issued or renewed unless the less that he or she is in good standing with the Department of Taxes."Good standing" means that no taxes are ducand payable and all been filed the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	Υου	must check one of the two statements below regarding taxes:
. 0	Ą.	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
	٥	I hereby certify that I am <u>NOT</u> 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
Fitle 21 §	1378	8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business
including	gali	cense to practice a profession) to, or enter into, extend or renew any contract for the provisitoof goods, services, or real estate
space wil	h an	y employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the
employin	g un	it is in good standing with respect to or in full complianc with a plan to pay any and all contributions or payments in lieu of
contribut	ions	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
ali contrii	outic	ons or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2)
ne napni	ty to	r any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliancitiwa
or payme	nts i	approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions in lieu of contributions due and payable would impose an unreasonable hardship.
3. :ontributi	ons:	
** ***	<b>∑i</b>	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with 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 <u>NOT</u> 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.
!		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.
ocial Se	curit	Date of Birth
he Depar	tmei	ure 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 not of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected and by the Office of Child Support

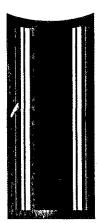
STATEMENT OF APPLICANT

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.







# National Commission on Certification of Physician Assistants

hereby affirms that

## **Anne Sarver Hildreth**

has successfully completed all certification requirements and earned the right to use the

## Physician Assistant-Certified designation.

Certificate Number: 1011311

Effective On: November 4, 2005

Expires On: December 31, 2007

Dorothy D. Pearson, PAC, Chairman of the Board

lanet I. Lathrop, President

Randy D. Danielsen, PhD, PA-C, Secretary

This certificate is property of NCCPA and must be returned upon request. This certificate does not constitute proof of certification. For valid proof of certification, contact NCCPA.

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

#### PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomp	plete applications will	be returned. Attach additi	onal sheets as needed.	
Name in full	GIBSON	- Chenal	A	
	(Last)	(First)	(Middle)	
Mailing Address	Planned 1	Parenthood		
183 Talcot	+ RP.	(Office Name)		
Williston (City/State)	TT. OS	(Street)	09/818-10	32
<b>\</b>	,		Telephone Number)	
Vermont License #:(	142-000146	5		
Hospital(s) where yo	ou have privileges:	Hospital(s) Loca	ation Specialty	
Fletcher A	Hen Health	care Burlin	yton obli	<del>a</del> N
What arrangements h	nave you made for sur	pervision when you are not	available or out of town:	
Covercia	e hi and	per Physician		
	CERTIFIC	CATE OF SUPERVISING	G PHYSICIAN	
HME HILDIE practice, attached to this	P.A. while application, does not exce	Chapter 31, I shall be legally respective under my supervision. I furthed the normal limits of my practive A, Chapter 31, Section 1741.	er certify that the protocol out	tlining the scope of
I further certify that I have 10151 (Date)	re read the statutes and Bo	eard rules governing physician at	Lup	
	Co-sig	gnature of PA:	O DAC	
Note: A PA who prescrib	es controlled drugs must o	obtain an ID number from DEA.	PA's DEA Number <u>你书</u> O	195984

LA# 025-003028Y

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

#### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incor	nplete applications w	vill be returned.	Attach additional sh	eets as needed.	
Name in full	Sm4h (Last)	Su (Fi	S <del>D</del> O	(Middle)	
Mailing Address _	Planned !	Paremho (Office Na	ome)		
<u> </u>	) (Z	(Street) Zip Code)	(Telepho	one Number)	2
Vermont License #	4: <u>042-000</u> 5	190			
Hospital(s) where	you have privileges:	Ho Tare	spital(s) Location	Specialty	<u>-</u> )
List all physician's Amy Boyerro August Britis Johanna Hau	s assistants names and Barre, VT.  S - Hyde AARK,  ISER-WINISTON,  CERTIFICATION	\(\frac{C\text{C}}{\text{VI}}\) \(\frac{C\text{C}}{\text{V}}\)	terine Michi tra Kinda Inot Yung Inne Hildret	OLOS-BUY INVO - BUYL, VI - BUYL, VI - BORREN NG PHYSICIAN	ton, NT.
aforesaid Physician A	n accordance with 26 VS, P.A. ossistant. I further certify its of my practice and the	only when the prim that the protocol or	ary supervising physicia ttlining the scope of prac	in is unavailable and onle ctice, attached to this app	y when consulted by the lication, does not
I further certify that I	have read the statutes and	XS	ning physician assistants  Men July  condary Supervising Phy	7	

PA# 055-0030584



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE

183 Talcott Road, Suite 101 Williston, VT 05495 Phone 802.878.7232 Fax 802.878.8001

December 15, 2005

State of Vermont-Board of Medical Practice 108 Cherry Street Burlington, VT 05401

To Whom It May Concern:

This is to certify that the Physician's Assistant named below has practiced under my supervision, in Vermont, within the last twelve months:

• Anne Hildreth ## 055-0030584

In addition, the Physician's Assistant named above maintains a Drug Enforcement Agency certification, and will be authorized to prescribe medications in accordance with Planned Parenthood's Scope of Practice, which has been submitted to and approved by the Vermont Board of Medical Practice.

Sincerely,

Cheryl Gibson Medical Director

## of Northern New England

The Family Planning Practitioner may:

- Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; A. midlife health; well child care; general preventive health care.
- Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol. В.

Manage routine hormonal contraceptive and HRT problems. 1)

- Order special laboratory tests needed to prescribe hormonal contraceptives and HRT. 2) 3)
- Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol. 1) C.

Manage routine Norplant problems. 2)

Inject Medroxyprogesterone acetate (Depo-provera) in accordance with PPNNE Medical Protocol. 1) D.

Manage routine DMPA problems. 2)

Insert and remove IUD's in accordance with the PPNNE Medical Protocol. 1) E.

Manage routine IUD problems.

- Order X-rays and sonograms for IUD localization. 2) 3)
- Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol.

1) Manage diaphragm and cervical cap problems. 2)

Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol. 1) G.

Manage condom and spermicide problems.

- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control: BBT, sympto-thermal, cervication and support of the natural methods of birth control in the natural method in the natural m H. mucus and calendar.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical ١.
- Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws. J.
- Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol K.
- Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms L.
- Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements. M.
- Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol. N.
- Perform venipuncture; start and maintain I.V.'s. O.
- Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNI Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parents Q. consent if the minor may suffer probable health hazards if such services are not provided.

The Family Planning Practitioner must

Adhere to the PPNNE Medical Protocol.

Obtain physician consultation in all non-routine clinical matters.

Follow-up and report all complications and all potential medico-legal incidents to the Medical Director.

I agree to practice under the above standing orders

Print Name

Collaborating Physician: Cheryl Gibson, M.D., Medical Dire

Signature

PPNNE Form 10HR 9/21/04es

Anne Hildreth PA# 055-0030584

#### Medical Oversight at Planned Parenthood of Northern New England

#### Physician Oversight

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol before functioning in an independent capacity. If further training in any expected area of competence is needed, this is arranged.

The Medical Director, a board certified OB/GYN., provides oversight and supervision through on-site visits and consultations, telephone consultations and quarterly in-services. She is available for telephone back up on a 24-hour basis. In addition, the Medical Director works with the Medical Management Team and the Director of Clinical Quality Improvement to develop and review protocols, audits, and to evaluate any new developments in the medical field that may affect PPNNE. All PPNNE mid-level practitioners practice under Standing Orders developed by the Medical Director. Practitioners attend quarterly continuing education in-service for medical training, discussion of protocol questions and other practice concerns. They also attend outside CME conferences. In addition, we have community Physicians who are available to our staff for consultation, telephone back up and review of charts.

#### **Practice Protocols**

Our medical protocol is based on standards set by Planned Parenthood Federation of America, and the U.S. Department of Health and Human Services. Comprised of nationally recognized experts in specialties and sub-specialties of reproductive healthcare, the National Medical Committee establishes standards and guidelines that all Planned Parenthood Federation of America affiliates must follow. This committee provides us with updates and revisions to the PPFA standards and guidelines on an on-going basis. These are incorporated into PPNNE'S protocol.

#### Medical Management Team

This team meets quarterly to discuss various medical management issues and to determine appropriate resolution of these issues under the Medical Director's guidance and final approval.

#### Director of Clinical Quality Improvement

The Director of Clinical Quality Improvement develops, oversees and conducts on-going audits of our medical programs.

- 1. Quality Assurance Site Audit:
  - The Director of Clinical Quality Improvement conducts an extensive annual on-site evaluation of each clinic. The audit includes a comprehensive review of charts, laboratory and pharmacy logs and practitioner performance, as well as an evaluation of the safety of the clinic.
- 2. Medical Record and Patient Care Audits:
  Medical Record and Patient Care Audits are conducted three times each year. The specific

topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topics include: follow-up of abnormal pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

Results of all these audits are shared with all medical staff. Corrective measures are taken when indicated, and re-audits conducted when sites are found to be out of compliance.

Ann Hildreth PA# 055-0030584

## PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's <u>Scope of Practice</u> for Physician's Assistants consists of several documents:

- 1) PPNNE Standing Orders: Each P.A. practitioner annually signs the <u>Standing Orders</u> that are approved by PPNNE's Medical Advisory Committee then cosigned by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.
- 2) <u>PPNNE's Medical Protocol</u>: The exact duties of the P.A. are clearly defined in PPNNE's <u>Medical Protocol</u>, a copy of which is on file with the Vermont Board of Medical Practice.
- 3) <u>Medical Oversight at PPNNE</u>: Please refer to the attached document, <u>Medical Oversight at PPNNE</u>, for information about the structure of supervision of P.A.'s at PPNNE.
- 4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

As specified in Section I, Part I of the PPNNE <u>Medical Protocol</u>, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

#### **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 ASSISTANT CERTIFICATION RENEWAL APPLICATION

#### PARTI

Certificate #055-0030584

1	Name:	Anne	Sarver	Hildreth	$PA_{-}C$

i. Name. Anne Sarver Hildre	eth PA-C		
2. Other Name(s), if any, un	der which you were certified or licens	sed in Vermont and elsewh	ere:
8. Work Andress:			
4 Home Address;	PPNNE- 6 RC	oberts North	nd. PPUVE 1 8950.Mans
City, State, Zip Code:	Ruttand, VT	05701	when, WH.
Please check your preferred (This	mailing address: KHome 🙃 s address will be public and listed on	Work the Board's website)	u OAR
5. Email Address			
6. Daytime Telephone <b>N</b> umb	er: Area Code:		
		F	A CONTROL OF THE PARTY OF THE P
7. Date of Birth:		DEC	; 2 6 2007
8. Place of Birth: _		Verm	ont Board of ical Practice
9. Certification Examination 1	aken – (Check box and enter date o		CE FERONO
× (10/21/07)	NCCPA		
O (/)	State Examination-Identify state:	74.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.4.	
· (//)	Other Examination specify:		
10. Basis for Vermont Certific	eation – (Check box):		

Apprenticeship Trained University Trained

11. Do you have hospital privi Hospital Name(s) and Locatio	
12. In what year did you start	working as a physician assistant in Vermont? <u>1999</u> 12101 (な
	nt during the past 12 months?
14. Other states where you no	ow hold an active certification or license to practice:
15. States where you previous	sly were certified or licensed to practice: MA. / N. H.,
16. Specialty: 0 B ( (	54N DEA Number: MHO1 95984
17. Name and office address	of current EMPLOYER:
Name	Address
PRUNE	183 Talcott Rd, willistop 01.
18. Please list (use additional as your PRIMARY and SECO	sheet if necessary) name(s) and address(es) of physicians who currently serve NDARY SUPERVISING PHYSICIAN(S).
Primary Supervising Physician	n(s):
Name	Address
Dr. Cherg Gi	0500 183 TalcottRd, Williston, UT
Secondary Supervising Physic	cian(s):
Name Dy-SUSA DS	int Address, 83 Talcotters, Williston, v
physician(s) review the mo additions or deletions in du have your PRIMARY SUP practice to this application.  a. Has there been a chang	ard of Medical Practice requires that you and your primary supervising set current scope of practice for your practice setting, paying attention to any uties and procedures. Please review, date and sign your scope of practice and ERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of
□ Yes <b>⊠</b> (No	•

21. Continuing Medical Education (CME) requirements:

Vermont Department of Health – Board of Medical Practice –

Physician Assistant within the past twelve months.

20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a

- a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
- b. For all others, an explanation of requirements and a CME Record form must be completed.

completed and returned with this application.
PART II
"Yes" answers to Questions 23 - 46 require an explanation on Form A.
23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes ၨÇ×qo
25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?
□ yes ¬Sy(o
26. 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
27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes □xno
28. 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 □ pvoj
29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes ট্প্o
30. Have you ever had staff privileges, employment or appointment in a hospital or other health care institutio denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
□ yes ≒x(no
31. 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
32. Are you presently or have you ever been a defendant in a criminal proceeding?

#### **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.

Page 3 of 19

□ yes & no

- 33. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
- 34. To your knowledge, are you presently the subject of a criminal investigation?



The following definitions are provided to assist you in answering questions 35 through 37.

"Ability to practice medicine" - This term includes:

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

35. 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?

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.

36. 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?

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.

37. Are vou currently engaged in the illegal use of controlled substances?

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, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

#### Part IV - Statutory Profile Questions

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 practitioner profile is located at the following website http://healthvermont.gov/hc/med\_board/profile\_search.aspx.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.

car	not process your applicat	tion without them.		
38.	Criminal Convictions [See	26 VSA § 1368(a)(1)]	Check here if none	
	Please provide a descri or parking tickets) of wh copies of documentat	iich you have been convi	es and misdemeanors; this cted within the past 10 yea	s includes DUI but not speeding ars <b>Please provide complete</b>
	(Conviction Date)	(Court)	(City/State)	(Crime)
39.	Nolo Contendere/Matters C	Continued [See 26 VSA	§ 1368(a)(2)]	ck here if none
	or where sufficient facts	of guilt were found and	nich you pleaded "nolo cor the matter was continued ete copies of document	ntendere" ("I will not contest it") I without a finding by a court of ation for each matter.
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
40.	Vermont Board of Medical I Please provide a descri Board of Medical Practi appealed.	ption of all formal charge	es served, findings, conclu	Check here if none usions, and orders of the such matters by the courts, if
	(Date)	(Final	Disposition - Summary)	
			, , , , , , , , , , , , , , , , , , , ,	

(Date) (Final Dis					Disposition - Summary)				
	(Date)		(Final Disposition - Summary)						
41.	41. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]  **Check here if none								
	states, the fi	ide a description on a nation of the national section	าร, and orders	of such authori	ties, and	final dispositi	on of such mat	ters by	
(Da	te of Final Dispo	sition) (Licens	ing or Certifica	ation Authority)	(Court)	(City/State)	(Nature of Ch	arge)	
(Dai	te of Final Dispo	sition) (Licens	ing or Certifica	tion Authority)	(Court)	(City/State)	(Nature of Cha	arge)	
42.	Restriction of Ho	ospital Privileges	[See 26 VSA	§ 1368(a)(5)]		heck here if	none		
	Revocation/	Involuntary Restri	ctions						
	were related official of the	de a description of to competence of hospital after prod nplete copies of	character and cedural due pro	d were issued b ocess (opportur	y the hos tity for hea	pital's govern	ing body or any	v other	
	(Date)	(Hospital)	(State)	(Nature of Re	estriction)	(Reason f	or Restriction)		
	(Date)	(Hospital)	(State)	(Nature of Re	estriction)	(Reason f	or Restriction)		
	B. Othe	er Restrictions	Check he	ere if none	C 1131	58			
	restriction of	de a description of privileges at a hosce or character in	pital taken in li	eu of, or in settl	ement of,	a pending dis	sciplinary case r	elated	
	MANAGEMENT								
	(Date)		(Ho	(Hospital)		(State)			
	(Nature of Ad	ction)	☐ In lieu	(Action)		,			
	(Reason for	Action)	⊔ III lieu	□ In settle	ment				
43	Medical Malprac	fice Court Judame	ants/Settlemer	ote [Soo 26 VS	A & 1360/	~\(C \ ) ]			

( )

A. <u>Judgments</u> 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

		complaining	party if not li	sted belo	w. Ple	nt date) in which a ase provide comp ssible, a copy of t	olete copi	es of doo	umentation.
		□ Judgment	☐ Arbitra	ation					
		(Date)	(Court)	(St	ate)	(Nature of Case)	(Amour	nt Assesse	ed Against You
		☐ Judgment	☐ Arbitra	ation					
		(Date)	(Court)	(Sta	ate)	(Nature of Case)	(Amour	nt Assesse	ed Against You
	B.	Settlements	X Check	here if n	one				
	·	within the pa complaining	st 10 years ( party if not li	10 years sted belo	from p w. <b>Ple</b> :	nents of medical mayment date) in wi ase provide comp sible, a copy of the	hich a pay <b>olete copi</b>	ment was	awarded to a umentation.
		(Date)	(Court)	(\$	State)	(A	mount of	Settlemer	t Against You)
		(Date)	(Court)	(8	State)	(A	mount of	Settlemer	nt Against You)
44.	Years of F What mo	<u>Practice</u> [See 2 nth and year di	6 VSA § 136 d you start p	88(a)(10)] racticing	as a P	hysician Assistant′i	6/198	84	
45.	you are gr	anting permissi	on to have tl	his inform	ation p	)] Note: Answering posted on the web. intments, these qu	(This form	n follows t	he statutory
	Α.	Appointments	Ē						
		Please provio faculties.	le informatio	n about y	our ap	pointments to med	lical schoo	of or profe	ssional school
		(School) (C	City)	(State)	(Nati	ure of Appointment	t) Froi	m (year)	To (year)
		(School) (C	City)	(State)	(Nati	ure of Appointment	;) From	n (year)	Го (year)
	В.	Teaching							
		Please provided education with	e informatio hin the past	n regardir 10 years.	ng you	r responsibility for	teaching g	graduate r	nedical
	(Schoo	ol/Institution)	(City)	(Sta	ite)	(Nature of Teachi	ng)	From (ye	ear) To (year)

	(Title)	(Publication)	(Vees)
	(140)	(i ubileation)	(Year)
	(Title)	(Publication)	(Year)
47.	Activities [See 26 VSA	A § 1368(a)(14)]	(1.54.7)
	Note: Answering #47 is posted on the web. Pleactivities and awards.	s optional. By answering, you are granting permission to have ease provide information regarding your professional or comr	e this information nunity service
		(Activities or Awards)	
48. <u>Pr</u>	actice Setting [See 26 \	/SA § 1368(a)(15)]	***************************************
<b>(2)</b>	What is the location of 89 SO. MON	your primary practice setting?  St. W.Lebaron, NH. 03784	
•	Town/City, State		
49. <u>Tr</u>	anslating Services [See	26 VSA § 1368(a)(16)]	
		nslating services available at your primary practice location. vices available at your primary practice location?  □ Yes 婦	No
	If yes, please describe	the translating services available:	
			***************************************
50. <u>M</u> €	edicaid/New Patients [Se	ee 26 VSA § 1368(a)(17)]	
	A. <u>Medicaid partic</u> Do you particip	cipation pate in the Medicaid program?	
	B. <u>New Medicaid</u>	<u>Patients</u>	
	Are you curren	itly accepting new Medicaid patients? ≺ဩ Yeṡ □ No	

Publications [See 26 VSA § 1368(a)(13)]

46.

#### Part V

I hereby affirm that the inform qu	nation provided above is true and accurate, and that I estions to the best of my knowledge and ability.	have answered the
Date: 11/18707	Volme 8 20 en	Ro
l ·	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

#### 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 onewelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasjudicial 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 mediate payment of support would

impose an u	inreasonable hardship. (15 V.S.A. § 795)
1. Yo	u 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 aptication: (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.
٥	or I hereby certify that I am <u>NOT</u> 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 ueasonable hardship. Please forward an "Application for Hardship".
person certi eturns have	Regarding Taxes  13 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the fies that he orshe is in good standing with the Department of Taxes."Good standing" means that no taxes are dueand payable and all been filed the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner Taxes, or a authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
s. Yo	u <u>must</u> check one of the two statements below regarding taxes: I hereby certify, under the pains and penalties operjury, 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 fineor both).
	I hereby certify that I am <u>NOT</u> 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 annueasonable hardship. Please forward an "Application for Hardship".
including a space with a employing u contribution ill contributi he liability fo payment pla	Regarding Unemployment Compensation Contributions 78 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade documents license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate my employing unit unless such employing unit shall first sign a written declaration, where the pains and penalties of perjury, that the nit 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 side 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 consor payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) or any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a napproved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment contributions in lieu of contributions due and payable would impose an unreasonable hardship.
. You	u <u>must</u> check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment s:
	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.)
	I hereby certify that I amNOT 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.
Þ	or I he <u>reby certify that 21 V.S.A. §</u> 1378 is not applicable tone because I am not now, nor have I ever been, an employer.
ocial Secur	ity #* Date of Birth
ie Departme	ure of your social security number is mandatory, it is solicited by a authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by ent of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected, 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 jeopardie my license/certification/registration status.

Signature of Applicant

V¢rmont Department of Health – Board of Medical Practice – 2008-2010 Physician Assistant Certification Renewal

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

#### PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	mplete applications w	vill be returned. Att	tach additional shee	ets as needed.	
Name in full	Gibson	Chen	<u>}                                    </u>	<u>A</u>	
	(Last)	(First)		(Middle)	
Mailing Address _	Planned	Parenthoc	<u>9d</u>		
183 Talc	oft RD.	(Office Name			
willisto		(Street)	3.88	3432	
(City/State	) (Z	ip Code)	(Telephon	e Number)	
Vermont License #	#: <u>042-000</u> 746	ioS			
Hospital(s) where	you have privileges:	Hospit	tal(s) Location	Specialty	
<del>Petcher Al</del>	iten Hearth a	are Bu	MIT. C	obloyn	
What arrangement	s have you made for s	supervision when you	ou are not available	or out of town:	
	CERTIFICATI	E OF SUPERVISI	NG PHYSICIAN		
the scope of practice, a	n accordance with 26 VSA P.A. w attached to this application hat a physician assistant is	thile under my supervisor, does not exceed the r	sion. I further certify the formal limits of my pra	nat the protocol outlining ctice. I further certify that	
I further certify that I I			physician assistants.  Aur  Supervising Physician)	Din E	
Note: A PA who presc	ribes controlled drugs mu	st obtain an ID number	r from DEA. PA's DEA	Number MHO195	984

#### STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

#### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	omplete application	is will be returned.	Attach additional shee	ets as needed.
Name in full	Smah	Susa	Jn	LEQUIAMINATION OF THE PROPERTY
	(Last)	(Fir	est)	(Middle)
Mailing Address	Planned	Parenthoe	<u>ja</u>	
183 Talo	of the	(Office Nat	me)	
Williston	<u> </u>	)5495 (Street)	-885	-8432
(City/State	e)	(Zip Code)	(Telephor	ne Number)
Vermont License	#: <u>049-000</u> 5	3990		
Hospital(s) where	you have privilege 100 H-Path	es: Hos CAYC B	spital(s) Location	Specialty OB OUT
Amy Box	man -90	and addresses you of Washington Story (1987) and the story (1987) and	St. Barrel	TT.  ZIK, VT.
C	ERTIFICATE OF	SECONDARY SU	UPERVISING PHYS	SICIAN UVEY-
consulted by the afore to this application, do	(CH), P., esaid Physician Assista	A. only when the priman ant. I further certify that all limits of my practice	Il be legally responsible for ry supervising physician is t the protocol outlining the e and that in accordance w	s unavailable and only when e scope of practice attached
I further certify that I  I 2 / (Date)	have read the statutes	and Board rules governi	ing physician assistants.  My Market Supervising Physic	)
and the second s		1997		



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE

183 Talcott Road, Suite 101 Williston, VT 05495 Phone 802.878.7232 Fax 802.878.8001

December 14, 2007

State of Vermont-Board of Medical Practice Attn: Tracy Hayes 108 Cherry Street Burlington, VT 05401

Dear Ms. Hayes,

This letter is to certify that the Physician's Assistant named below has practiced under my supervision, in Vermont, within the last twelve months:

Anne Hildreth

In addition, the Physician's Assistant named above maintains a Drug Enforcement Agency certification, and will be authorized to prescribe medications in accordance with Planned Parenthood's Scope of Practice, which has been submitted to and approved by the Vermont Board of Medical Practice.

Sincerely,

Cheryl Gibson, M.D.

## PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents: 1)

- PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by DDATATED A Committee then co-Orders that are approved by PPNNE's Medical Advisory Committee then cosigned by PPNNE's Medical Discott signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.
- 2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in the Vermont Board PPNNE's Medical Protocol: The exact duties of the P.A. are clearly using the of Medical Practice. of  $M_{
  m edical} \overline{P_{
  m ractice.}}$ 3)
- Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE. for information of supervision of Oversight at PPNNE: Please refer to the attached document, MICLE P.A.'s at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE. 4)
- Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of N. A. Pract P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fourteen outpations and is a non-profit health care to the contract of the contract o organization with fourteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director Dr. Additional St. Additional St. Additional St. Additional St. Additional Control of PPNNE. supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient ormalization. health centers provide outpatient synelogical and preventive care for women and men as outlined in PPNNE's Standing of Protocols. and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding for scale in the care access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing some to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermontons with pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical corrections are in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic and th handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

NCCPA
12000 Findley Road
Suite 200
Dujuth, GA 30097
Tel: 678417-8100 Fax: 678-417-8135
Web: www.nccpa.net E-mail: nccpa@nccpa.net
This card does not constitute proof of certification.
Please contact NCCPA for verification.

National Commission on Certification of Physician Assistants

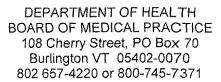
Anne Sarver Hildreth

Anne Sarver Hildreth

Anne Sarver Heation

Anne Sarver Heation

12/31/2009





#### 2010 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

#### PART I

Certificate #055-0030584	.,,,,,,	
1. Name: Anne Sarver Hildret	h PA-C	
2. Other Name(s), if any, und	fer which you were certified or licensed in Vermont	and elsewhere:
3. Work Address:		
4. Home Address:		
City, State, Zip Code:		/
5. Email Address:	address will be public and listed on the Board's we	bsite)
6. Daytime Telephone Numbe	r: Area Code:	
7. Date of Birth:		JAN -8 2010
8. Place of Birth: _		
Certification Examination Ta	sken – (Check box and enter date of examination):	A STATE OF THE STA
G ( <u>/_/</u> )	NCCPA	
	State Examination-Identify state:	
· (//)	Other Examination specify:	
10. Basis for Vermont Certifica	tion – (Check box):	
□ Apprenticeship Tra	ained	

11. Do you have hospital privileges in Vermont? ☐ Yes ₩ No Hospital Name(s) and Location(s):						
12. In what year did you start working as a physician assistant in Vermont?						
13. Were you in active clinical practice in Vermont during the past 12 months? ☑ Yes ☐ No						
14. Other states where you now hold an active certification or license to practice:						
15. States where you previously were certified or licensed to practice:						
16. Specialty: DB Gyn DEA Number: MHO195984						
17. Name and office address of current EMPLOYER:						
Name Address						
PPINDE						
18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).						
Primary Supervising Physician(s):						
Name Address						
Chery 6, book 23 monstrad Are. Burl, VT. 05401						
Secondary Supervising Physician(s):						
Name Address						
SUSAN MAT 23 Manstreld Ave. BUNLYT. 0540/						
19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.						
a. Has there been a change in your scope of practice which has not been reviewed by the Board? ☐ Yes 幫No						
20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a						

Physician Assistant within the past twelve months.

(21) Continuing	Medical	Education	(CME)	requirements

- a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
- b. For all others, an explanation of requirements and a CME Record form must be completed.

<ol> <li>Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.</li> </ol>
PART II
"Yes" answers to Questions 23 - 47 require an explanation on Form A.
23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art? □ yes 🛛 no
24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
🗆 yes 🔪 no
25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
a yes 🗝 no
26. 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
27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes 🐞 no
28. Have you ever discontinued your education, training, or practice for a period of more than three months?
□ yes 🚁 no
29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes 💣 no
30. 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
31. 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

32. 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

33. 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.

- 34. 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?
- 35. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

The following definitions are provided to assist you in answering questions 36 through 38.

"Ability to practice medicine" - This term includes:

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

36. 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?

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.

37. 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?

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 Vermont Department of Health – Board of Medical Practice – 2010-2012 Physician Assistant Certification Renewal

ongoing treatment (with or without medication) or have participated or do participate in a monitoring program. 38. Are you currently engaged in the illegal use of controlled substances? 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, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners. including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line). Part IV - Statutory Profile Questions 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 practitioner profile is located at the following website http://healthvermont.gov/hc/med\_board/profile\_search.aspx. Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them. Check here if none 39. 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 Please provide complete copies of documentation for each matter.

of Medical Proled.  or Certification of Hospital Properties of Hospital Procession of Hospi	n Authority e scription of conclusion ed, in those	f all formal cons, and orders states. Place	Final Disconnections), Final Disconnection A	sposition tates [Se served by ch authori ovide con	- Summar ee 26 VSA / licensing ities, and fi mplete co	, ,	ies of othe matters by			
or Certification ck here if non- e provide a desthe findings, curts, if appeals r.  Disposition)  of Hospital Pation/Involunts	escription of conclusion ed, in those (Licensia)	f all formal cas, and order e states. Plea	Other S harges rs of suc ease pro	served by ch authori ovide con	e 26 VSA vicensing ities, and firmplete co	§ 1368(a)(4)] or certification authority nal disposition of such pies of documentation (City/State) (Nature o	matters by			
e provide a des the findings, ourts, if appeale Disposition)	escription of conclusion ed, in those (Licensia)	f all formal cons, and orderes states. Place and or Certification (See 26 VSA)	harges rs of suc ease pro- cation A	served by ch authori ovide con outhority)	/ licensing ities, and fi <b>mplete co</b> (Court)	or certification authorit nal disposition of such pies of documentation (City/State) (Nature o	matters by			
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n of Hospital P ation/Involunta	rivileges (	See 26 VSA		,	,		f Charge)			
ation/Involunta		•	\ § 1368	B(a)(5)]	<b>₩</b> C	heck here if none				
•	ary Restric	ctions								
nrovido o do		Revocation/Involuntary Restrictions								
elated to comp	oetence or I after proc	character a edural due p	nd were process	e issued b (opportur	y the hosp nity for hea	on of your hospital privital's governing body or ring) was afforded to yo	r anv othe			
(H	lospital)	(State)	(Na	ture of Re	estriction)	(Reason for Restrict	ion)			
Other Restri	ctions	Check	here if n	none						
ion of privilege petence or ch	es at a hos	pital taken ir	lieu of,	or in settl	ement of, a	a pending disciplinary o	ase related			
(Date)		(Hospital)			(State)					
, , , , , , , , , , , , , , , , , , ,		□ In lieu		,	ement					
on for Action)										
	Other Restri	ion of privileges at a hos petence or character in natter.  e of Action) on for Action)	Other Restrictions Check provide a description of all resignation of privileges at a hospital taken in petence or character in that hospital natter.  (Heap of Action)	Other Restrictions Check here if reprovide a description of all resignations from ion of privileges at a hospital taken in lieu of, petence or character in that hospital. Pleas natter.  (Hospital on for Action)	Other Restrictions Check here if none provide a description of all resignations from, or non-ion of privileges at a hospital taken in lieu of, or in settle petence or character in that hospital. Please providenatter.  (Hospital)  e of Action)  In lieu  In settle on for Action)	Other Restrictions	Other Restrictions			

Check here if none

A.

<u>Judgments</u>

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 reporte	d	9.1 1	r yumb		
		□ Judgment	□ Arbitration				
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You	<u> </u>
		□ Judgment	□ Arbitration				
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You	)
	B.	<u>Settlements</u>	Check here	if none			
		within the past complaining pa	10 years (10 yearty if not listed al disposition	ears from below. <b>Pl</b> e	payment date) in w ease provide com	nalpractice claims against you hich a payment was awarded to a plete copies of documentation, he complaint for each matter.	
		(Date)	(Court)	(State)	(/	Amount of Settlement Against You)	
		(Date)	(Court)	(State)	(/	Amount of Settlement Against You)	
45.	Years of F	<u>Practice</u> [See 26	VSA § 1368(a)	(10)] <b>19</b>	84		
	What mo	nth and year did	you start praction	cing as a F	Physician Assistant	2 6/1984	-
46.	you re gra	nting permission	to have this infe	ormation p	osted on the web.	g #46 is optional. By answering, (This form follows the statutory uestions may overlap.)	
	A.	Appointments					
		Please provide faculties.	information ab	out your a	ppointments to me	dical school or professional school	
		Dartmouth					
		Hanover, NH					
		Adjuinct Facu	lty				

		(School)	(City)	(State)	(Nature of Appointment)	From (voor) To (voor)					
		(3011001)	(City)	(State)	(Nature of Appointment)	From (year) To (year)					
		(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)					
	В.	Teaching									
	Please provide information regarding your responsibility for teaching graduate medical										
education within the past 10 years.											
	(Schoo	ol/Institution	) (City	) (Sta	ate) (Nature of Teaching)	From (year) To (year)					
47.	Publics	ations (Saa	26 VSA § 13	68(a)(13)I							
	1 001100	<u> </u>	20 10/13 10	00(4)(10)]							
	Note: /	Answering #	47 is optiona	l. By answe	ring, you are granting permis	ssion to have this information					
			.  Please prov e past 10 yea		ation regarding your publicati	ons in peer-reviewed medical					
	None	reported									
None reported											
	(Title)			(F	Publication)	(Year)					
(Title) (Publication)						(Year)					
48.	48. <u>Activities</u> [See 26 VSA § 1368(a)(14)]										
	Note: Answering #48 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.										
None reported  (Activities or Awards)											
49. <u>Pr</u>	actice Se	etting [See	26 VSA § 136	88(a)(15)]							
	What is the location of your primary practice setting?										
6 Roberts North Rutland, VT.											
	Town/C	City, State									
50. <u>Tr</u>	anslating	Services [	See 26 VSA	§ 1368(a)(1	6)]						
	Please	identify any	translating s	ervices ava	ilable at your primary practic						
	Are any	y translating	Are any translating services available at your primary practice location? ■ Yes □ No								

 $Vermont\ Department\ of\ Health-Board\ of\ Medical\ Practice-2010-2012\ Physician\ Assistant\ Certification\ Renewall$ Page 8 of 1

If yes, please describe the translating services available:

None

51.	Medicaid/N	New Patients [See 26 VSA § 1368(a)(17)]
	A.	Medicaid participation  Do you participate in the Medicaid program?
	B.	New Medicaid Patients
		Are you currently accepting new Medicaid patients? ■ Yes □ No
		Part V
	I hereby af	firm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.
Dat	e://	20109 Onne Hilde Pac
	į	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

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	mplete applications will	be returned. Attach add	litional sheets	as needed.
Name in full	Gibson	Chenil		4
ı	(Last)	(First)		(Middle)
Mailing Address _	Monned P	arrenthood d		
	33 Mansf	(Office Name)	_	
(0), (0)	Burlington	(Street)	8639	001
(City/State)	(Zip)	Code)	(Telephone N	(umber)
Vermont License #	:042-000146	5		
Hospital(s) where	ou have privileges:	Hospital(s) Lo	cation	Specialty
Aelderz	HIEN Hearth C	ABE Build	ston	OBJOUN
What arrangements	have you made for supe	ervision when you are no	ot available on	
SULLAND	211 (20///00	<u> </u>	n available of	out or town:
<u>27710110</u>	+112EMCE	Concred to	two wit	7.7.
V	CERTIFICATE O	F SUPERVISING PHY	YSICIAN	
the scope of practice, at	accordance with 26 VSA, Checker P.A. while tached to this application, do at a physician assistant is use	under my supervision. I furt	her certify that th	e protocol outlining
I further certify that I ha	ive read the statutes and Boar	rd rules governing/physician	assistants.	
(Date)		- Chil	Ms	
(Date)		(Signature of Supervisin	g Physician)	
		nature of PA	ortiba	246
Note: A PA who prescri	bes controlled drugs must ob	tain an ID number from DEA	PA's DEA Nu	mber 17410195984

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	mplete applications wil	ll be returned. Attach add	ditional sheets as needed.	
Name in full	Smith	SUSAN	- September -	
	(Last)	(First)	(Middle)	
Mailing Address _	Planned	Parenthood		
Was subsected by	as Man	(Office Name)		
	Burlingto	N (Street) N (TT. 0540)	863-900/	
(City/State	$\vee$ (Zip	o Code)	(Telephone Number)	
Vermont License	#: <u>042-000</u> 599	70		
Hospital(s) where	you have privileges:	Hospital(s) Lo	ocation Specialty	
FAHC	BUMY	noton	OBIGIN	
Hony borg	man 90 was	addresses you currently s hington St. R anstreld Ave ts North Rutla	upervise:  ATT.  BURLYT-  AND. VT. (VER)	7
CF	ERTIFICATE OF SEC	CONDARY SUPERVIS	ING PHYSICIAN	
consulted by the afore to this application, does	said Physician Assistant. I t	y when the primary supervisir further certify that the protoco nits of my practice and that in	responsible for all medical activities on ag physician is unavailable and only well outlining the scope of practice, attact accordance with 26 VSA, Chapter 31	hen hed
		oard rules governing physician	n assistants.	
12   29   00 (Date)	<u> </u>	Ollen (	J MMG	
(Date)	(	(Signature of Secondary Super	rvising Physician) '	

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomp	plete applications will	be returned. Atta	ch additional sl	neets as needed.
Name in full	Bayman	Kyn	1	<u></u>
	(Lasty	(PLPSUA)	*	(Middle)
Mailing Address	Manned	. Karenth	$\infty d$	
	23 Mar	(Office Name) SHELD A	ve.	
	BUNDS	(Street)	05401	863-900/
(City/State)	(Zip)	Code)	(Teleph	one Number)
Vermont License #:	042001059	9		
Hospital(s) where yo	ou have privileges:	Hospita	l(s) Location	Specialty
PAHC		Partinator	TVI.	ORIGIN
		<u> </u>		
Amy Borgma	ssistants names and acomposition of Wash	jarsfield	BARRE	<del></del>
CERT	IFICATE OF SECO	NDARY SUPER	VISING PHY	SICIAN OVER
of Home Hill of only when consulted by t practice, attached to this	ccordance with 26 VSA, C PV , P.A. or he aforesaid Physician Ass application, does not exce n 1741, the use of a physic	aly when the primary sistant. I further certi ed the normal limits o	supervising physic fy that the protoco of my practice and	ian is unavailable and
I further certify that I hav	ve read the statutes and Bo	ard rules governing p	hysician assistants	
1-5-1	<i>3</i>	:·	19	Addition to the state of the st
(Date)		Signature of Secondar	v Supervising Phy	sician)

# Vermont Department of Health — Board of Medical Practice

108 Cherry Street, P.O. Box 70

Burlington, VT 05402-0070

http://healthvermont.gov/hc/med\_board/bmp.aspx

802-657-4220

# Consent to Disclosure of Prescriber-Identifiable Information for, Marketing or Promoting Prescription Drugs

Under Vermont law, a prescriber may give consent so that his or her identifiable data in prescription drug records may be used for marketing or promoting prescription drugs. If a prescriber chooses not to consent, the use of prescriber-identifiable data in prescription drug records is restricted as provided for in the law. The text of the law is found at 18 V.S.A. § 4631, and a copy of the law appears on the reverse side of this consent form.

If you choose to consent to the use of your identifiable data in prescription drug records for marketing or promoting prescription drugs, please check the "I consent" box below and sign next to it. Your consent is effective for this licensing or certification period.

If you do not wish to consent, you do not need to complete this consent form.

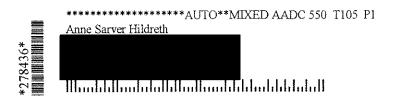
If you do complete this form, please return it to the Board of Medical Practice with your completed license or certification application or renewal form.

You may revoke your consent at any time by signing a Revocation of Consent form and sending it to the Board of Medical Practice. The Revocation form may be obtained directly from the Board or on the Board's website.

	Signature		Date
	Print Name	Vermont License or	
			Certification Number
Print M	ailing Address		
	Anne		
	Anna		
Telepho	one		

November 21 2009





Dear Physician Assistant-Certified designee:

Enclosed you will find your NCCPA wallet card for your next two-year certification cycle. Please note two important pieces of information: your Dec. 31, 2011 certification expiration and your 7-digit NCCPA identification number.

In our technologically-savvy world, the risk of fraudulent use and falsification of paper documentation is increasing. Thus, to help safeguard the integrity and security of the PA-C credential, NCCPA has eliminated the paper certificates once issued to PAs every two years. This change to issuing only a wallet card is aimed at curtailing the use of the printed certificate as proof of certification. The only valid proof of NCCPA certification is primary source verification through the NCCPA.

We encourage you to use the Verify PA Certification tool on our Web site (<a href="www.nccpa.net">www.nccpa.net</a>). This tool allows you, your employer, state licensing board or others to obtain the primary source verification that you need with just a few clicks, provided at no cost to you. The tool provides you the flexibility to print the Web screen, request an e-mailed PDF file or a mailed letter. The tool also offers you the flexibility to have NCCPA submit your certification information directly to a third party by entering their contact information.

For those desiring a document appropriate for display commemorating your achievement of NCCPA certification, we provide such a document that has no expiration date. If you are interested in receiving one, please contact us at <a href="mailto:nccpa.net">nccpa@nccpa.net</a>.

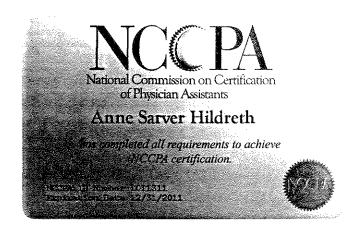
Please note that for your 2009-2011 certification maintenance cycle, the deadline for earning and logging the required CME hours and paying the certification maintenance fee is **June 30, 2011** to receive the **\$50 discount**. Log your hours online at <a href="https://www.nccpa.net">www.nccpa.net</a> as you earn them to keep a running total. While there, you can also view a personalized record of all your certification maintenance requirements.

Sincerely,

Cirray L. NAIIS

Cindy L. Nalls Manager of Certification Maintenance

P.S. NCCPA is making a conscious effort to protect the environment. As part of our efforts, we are "going green". With that in mind, as of the 2008-2010 certification maintenance cycle, we are no longer accepting paper logging forms. Please don't hesitate to contact us for assistance if you are new to our online CME logging process.



#### CENTRAL OFFICE

183 Talcott Road, Suite 101, Williston, VT 05495 Phone 802-878-7232 # Fax 802-878-8001

December 17, 2009

State of Vermont-Board of Medical Practice Attn: Tracy Hayes 108 Cherry Street Burlington, VT 05401

Dear Ms. Hayes,

This letter is to certify that the Physician Assistant named below has practiced under my supervision, in Vermont, within the last twelve months:

Anne Hildreth

In addition, the Physician's Assistant named above maintains a Drug Enforcement Agency certification, and will be authorized to prescribe medications in accordance with Planned Parenthood's Scope of Practice, which has been submitted to and approved by the Vermont Board of Medical Practice.

Sincerely,

Cheryl Gibson, M.D.

# PHYSICIAN ASSISTANT SCOPE OF PRACTICE at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's <u>Scope of Practice</u> for Physician's Assistants consists of several documents:

- 1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then cosigned by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.
- 2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.
- 3) <u>Medical Oversight at PPNNE</u>: Please refer to the attached document, <u>Medical Oversight at PPNNE</u>, for information about the structure of supervision of P.A.'s at PPNNE.
- 4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with thirteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

As specified in Section I, Part I of the PPNNE <u>Medical Protocol</u>, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

Physician Assistant (ANNE Hidreth)

Date

12/22/09

Date

12/22/09

Date

# PLANNED PARENTHOOD of Northern New England

# Standing Orders: Nurse Practitioners, Certified Nurse Midwifes & Physician Assistants

# The Family Planning Practitioner may:

- Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common Α. gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; midlife health; general preventive health care.
- В. 1) Order and dispense hormonal contraceptives and HT/ET in accordance with the PPNNE Medical Protocol.
  - Manage routine hormonal contraceptive and HT/ET problems. 2)
  - Order special laboratory tests needed to prescribe hormonal contraceptives and HRT. 3)
- Insert and remove implant contraceptive systems in accordance with the PPNNE Medical Protocol. 1) C.
  - Manage routine implant system problems. 2)
- D. 1) Inject Medroxyprogesterone acetate in accordance with PPNNE Medical Protocol.
  - 2) Manage routine DMPA problems.
- Insert and remove IUD's in accordance with the PPNNE Medical Protocol. 1) Ε.
  - 2) Manage routine IUD problems.
  - Order X-rays and sonograms for IUD localization. 3)
- Fit and check diaphragms, cervical caps and other barrier devices in accordance with the PPNNE Medical Protocol. 1) F
  - Manage diaphragm, cervical cap and other barrier device problems. 2)
- Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol. 1) G.
  - Manage condom and spermicide problems. 2)
- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical Η. mucus and calendar.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and 1\_ other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
- Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.
- Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol. K.
- Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, and sonograms.
- Provide services to patients in the abortion, cervical dysplasia, infertility, male services, and midlife programs as per the M. PPNNE Medical Protocol and Medical Protocol Supplements.
- Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up N. routine and problem patients in accordance with the PPNNE Medical Protocol.
- 0. Perform venipuncture; start and maintain I.V.'s.
- Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Ρ, Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and Q. especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

### The Family Planning Practitioner must:

- Adhere to the PPNNE Medical Protocol.
- В. Obtain physician consultation in all non-routine clinical matters.
- Follow-up and report all complications and all potential medico-legal incidents to the Medical Director.

Date

I agree to practice under the above standing orders

Print Name

Signature

Collaborating Physician: Cheryl Gibson, MD, Medical Director

# 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: Anne Hilden RC

Date: 1/12/10

# Vermont Department of Health - Board of Medical Practice

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

Regarding Child Support

support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support payable under a 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)
--

or liability	for by t	any support pavable	good standing with respect to or in full compliance with a plan to pay any and all child support payable under a pplication is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan port or agreed to by the parties; or the licensing authority determines that immediate payment of support would (15 V.S.A. § 795)
1.	You	and I am in good sta	e two statements below regarding child support regardless whether or not you have children: 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 nding 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 due under that order.
	ם ֹ	- Janes arrang arra 1600	or am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby using authority determine that immediate payment of child support would impose an unreasonable hardship.
returns ha	eve t	een filed, the tax lial	Regarding Taxes lessional license or other authority to conduct a trade or business shall not be issued or renewed unless the good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and al ility is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, o that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2. i	4	I hereby certify, unde to pay any and all ta	two statements below regarding taxes: The pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan The state of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen
,	<b>-</b>	I hereby certify that it I hereby request that	or am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application an the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship.
space with employing contributional contribution the liability payment por paymen	n any unitions of ution of for lan of	y employing unit unie t is in good standing due as of the date su as or payments in lie any contributions or approved by the Com lieu of contributions	Regarding Unemployment Compensation Contributions ency of the state shall grant, issue or renew any license or other authority to conduct a trade or business ofession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate ss such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of the declaration is made. For the purposes of this section, a person is in good standing with respect to any and of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a missioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions due and payable would impose an unreasonable hardship.
			three statements below regarding unemployment contributions or payments in lieu of unemployment
>	1	payments in lieu of u application. (The ma	the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a ed by the Commissioner of Employment and Training to pay any and all unemployment contributions or nemployment contributions to the Vermont Department of Employment and Training due as of the date of this kimum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both.)
C	ŧ	he licensing authorit	am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment the Vermont Department of Employment and Training as of the date of this application and I hereby request that y determine that requiring immediate payment of unemployment contributions or payments in lieu of butions would impose an unreasonable hardship. Please forward an Application for Hardship.
C	) I	hereby certify that 2	or I V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.
iocial Sec	urity	#*	Date of Birth
		e of your social secu of Taxes and the De nd by the Office of C	rity number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by partment of Employment and Training in the administration of Vermont tax laws, to identify individuals affected hild Support.
			STATEMENT OF APPLICANT
certify tha Iformation	t the	information stated b mission of informati	y me in this application is true and accurate to the best of my knowledge and that I understand providing false on is unlawful and may jeopardize my license/certification/registration status.

Date\_ Vermont Department of Health - Board of Medical Practice - 2010-2012 Physician Assistant Certification Renewal Page 23 of 1

National Commission on Certification of Physician Assistants

# Anne Sarver Hildreth

Ras completed all requirements to achieve NCCFA verification.

A ID Number 1011311 ration Date 12/31/2011





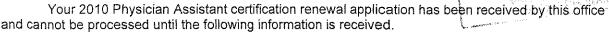
# Department of Health

**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

Date: January 8, 2010

Dear Physician Assistant:



and car	nnot be proc	essed until the following	g inform	atior	is rece	ived.		An AMERICAN, CO.	J		
		\$115 renewal fee \$50 renewal fee Additional \$65 renewal t	fee								
Applicat	ion										
	Part I	Item 1 Item 2 Item 3 Item 4 Item 5 Item 6 Item 7 Item 8 Item 9 Item 10 Item 11 Item 12 Item 13 Item 14 Item 15 Item 16 Item 17 Item 18 Item 19 Item 19 Item 19 Item 20	Part III Part IV		Item 21 Item 22 Item 23 Item 24 Item 25 Item 26 Item 27 Item 28 Item 30 Item 31 Item 31 Item 32 Item 34 Item 35 Item 36 Item 37			Part V		Item 39 Item 40 Item 41 Item 42 Item 43A Item 43B Item 44A Item 44B Item 45 Item 46A Item 46B Item 47 Item 48 Item 49 Item 50 Item 51A Item 51B Date Signature	
Child Su Stateme	nt Comple	Number 1 – check one of statements Number 2 – check one of statements Number 3 – check one of statements Number 3 – check one of statements ted form A ted Statement of Good Statements	of the two	e				Secondary Application( Primary Sul work for pass Scope of Printification	pervis Supe (s) pervis st yea ractio	ce Certification	ı
The	nage(s) tha	at needs completion (if	annlicah	ه (ما	attach	ad Dlar	300	complete th	o no	coccan itam	

The page(s) that needs completion (if applicable) is attached. Please complete the necessary ite initial, date and return as soon as possible so that processing may be finalized. Thank you.

# 1958°

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomp	lete applications will be	returned. Attach add	itional sheets as	needed.	
Name in full	Theiler (Last)	Regan (First)		Middle)	
Mailing Address	23 mans	Held Aver (Office Name)	rye		
(City/State)	(Zip Co		803-62 (Telephone Nu	mber)	
Vermont License #: _	<u>090700100</u>	.07			
Hospital(s) where you	a have privileges:	Hospital(s) Lo	cation	Specialty	
Application	u lu bocez i	with faith.	<u> </u>	Blayn	
What arrangements h	ave you made for super	vision when you are n	ot available or o	ut of town:	
	CERTIFICATE OF S	SUPERVISING PHY	SICIAN		
of Anne Hidre outlining the scope of pra	P.A. while circe, attached to this applicate will be posted that a physicial	e under my supervision. I ation, does not exceed the	further certify that normal limits of my	the protocol / practice. I	
I further certify that I hav	e read the statutes and Board	l rules governing physiciar	assistants.		
8/2/u (Date)		(Signature of Supervisi	ing Physician)		
	X Co-signa	ature of PA:	e. Hil	Dist Tac	
Note: A PA who prescrib	/ es controlled drugs must obt	tain an ID number from DI	EA. PA's DEA Nu	mber MH1080956	****

2594

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET

BURLINGTON, VT 05401 (802) 657-4220

APR 2 0 2011

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	mplete applications will	be returned. Attach add	lditional sheets as needed.
Name in full	Towara	Kathleen	mane
	(Last)	(First)	(Middle) .
Mailing Address _	Planned	Parenthood	Junearian
	183 Tal	(Office Name)	
<u> </u>	willistan	(Street) 05495	288-8432
(City/State	) (Zip 6	Code)	(Telephone Number)
Vermont License #	#: 042-001216	3	
Hospital(s) where	you have privileges:	Hospital(s) Lo	ocation Specialty
PORTOMALA	b Regional Hes	stal botaner	thing obtain
What arrangement	s have you made for sup	ervision when you are r	not available or out of town:
8410 OX	JOHN SANCE		
	CERTIFICATE OF	SUPERVISING PHY	YSICIAN
outlining the scope of	practice, attached to this appl	hile under my supervision. ication, does not exceed the	y responsible for all medical activities I further certify that the protocol e normal limits of my practice. I cordance with 26 VSA, Chapter 31,
I further certify that I	have read the statutes and Boa	ard rules governing physicia	an assistants,
411111 (Date)		X Katheen / (Signature of Supervise	A Commence of the Commence of
		nature of PA	ne Helon
Note: A PA who preso	ribes controlled drugs must c	htain an III numhar fram D	DEA PA'S DEA Number MH178793

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

APR 2 0 2011

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	nplete applicat	tions will be re	turned. Attach	additional she	ets as needed.
Name in full	Novell	0	Benec		
	(Last)		(First)		(Middle)
Mailing Address _	Plan		athooc		
	-681	Talcott	ffice Name) - Road		
	<u> </u>	ston, vr.	05495	386	-8432
(City/State)	•	(Zip Code	)	(Telephor	ie Number)
Vermont License #	:042-00	Tildz			
Hospital(s) where	you have privil	eges:	Hospital(s)	Location	Specialty
MT. ASCUTO	rey Host	Hal	windso	Y,VT.	OB GUN
- <del>1111.1</del>	<del></del>				-00109i
List all physician's	assistants nam	nes and address	ses you currently	/ supervișe:	
Johanno H		13 Marsh		burling	100,11.
Collegne N		<i>n</i>		<u> </u>	VI.
JAMEL YOU	$\Sigma$	k le	U	11	· I
CER	TIFICATE O	F SECONDA	RY SUPERVIS	SING PHYSI	CIAN
I hereby certify that, in of ATONE HAND only when consulted by practice, attached to the VSA, Chapter 31, Sect.	Seth the aforesaid Ph s application, doe	, P.A. only who ysician Assistant. es not exceed the	en the primary supe I further certify the normal limits of my	ervising physician at the protocol or practice and that	n is unavailable and
* 523, Chapter 51, 300t	on 1741, the use	or a physician ass	isiani nas occii pos	icu.	
I further certify that I h	ave read the statu	tes and Board rul	es governing physic	cian assistants.	
4/13/11		X	KULERO	<u>UL</u>	And the second discount of the second
/ (Daté)		(Signatu	re of Secondary Su	pervising Physic	ian)

W ASA

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	mplete applications wil	l be returned. A	Attach additional shee	ets as needed.
Name in full	Novello	Ren	ree	and the second s
	(Last)	(Firs	st)	(Middle) .
Mailing Address _	Planne	1 Parent	hood	
	6 Roba	Office Nam	ieth .	
	Ruttan	d (Street) $0$	5701 775-	2333
(City/State	) (Zip	Code)	(Telephon	e Number)
Vermont License #	#:042,001119	5		
Hospital(s) where	you have privileges:	Hosp	oital(s) Location	Specialty
MT. ASC DHMC	utney Hosp		ndsor VIII	OB GUN
What arrangement	s have you made for su	pervision when	you are not available	or out of town:
24/70	N Call Sen	tce	MANAGE TO THE PROPERTY OF THE	
	CERTIFICATE O	F SUPERVISI	NG PHYSICIAN	
outlining the scope of	practice, attached to this applice will be posted that a phy	while under my sup plication, does not	pervision. I further certify exceed the normal limits	y that the protocol of my practice. I
I further certify that I I  3/4/2016 (Date)	nave read the statutes and Be	X1/9/4	gphysician assistants.  Wllm  of Supervising Physician)	· · · · · · · · · · · · · · · · · · ·
	Co-si	gnature of PA:	Invertible	DR.
Note: A PA who presc.	ribes controlled drugs must	obtain an ID numh	per from DEA PA's DE	4 Number MV226519

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET

BURLINGTON, VT 05401 (802) 657-4220

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incompl	ete applications will be r	returned. Attach addit	ional sheets as n	eeded.
Name in full	Gibson	_cherul	Д	
	(Last)	(First)	(N	Middle)
Mailing Address _ P		athood		
18	33 Talcott	Office Name) RD.		
(City/State)	Ullistan, VI	Street) 05495	288-8K	132
(City/State)	(Zip Cod	e) (	Telephone Numi	ber)
Vermont License #: 🔘	420007465			
Hospital(s) where you	have privileges:	Hospital(s) Loca	ation Sp	ecialty
FAHC	Burlington	1771.	OB	toyn
Tube Doiding	istants names and addres  DON 90 WASHI  USEC 23 MARSE  The 6 Roberts	ngton st. Bai	ervise: Me, VT · O: IVNSTON, VI L, VT.	5641 -05901 -05901
CERTIF	ICATE OF SECONDA	ARY SUPERVISING	PHYSICIAN	(OVER)
only when consulted by the practice, attached to this app	ordance with 26 VSA, Chapte P.A. only whaforesaid Physician Assistant plication, does not exceed the 741, the use of a physician as	t. I further certify that the	g physician is unava	ailable and
I further certify that I have a (Date)	read the statutes and Board ru.	les governing physician as  W  ure of Secondary Supervis	<b>)</b>	
	1 , 3	or a recommend to a post of to	p v myanami	

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

# 2012 PHYSICIAN ASSISTANT LICENSURE RENEWAL APPLICATION

License # 055-0030584	Р	'ART I	The second secon
Name: Anne Sarver Hildreti	h PA-C	, passent the second se	1 C 0013
2. Other Name(s), if any, und	er which you were certified or li	censed in Vermont	JAN 1 6 2012 and elsewhere:
	<u> </u>	V V	
3. Mailing Address(es):		مُومَّ مُومَّ اللهِ	Andrews and the second sec
4. Home Address: _			
City, State, Zip Code:			
5. Email Address: _			***************************************
6 Daytime Telepho			
7. Date of Birth:	<b>2</b> - 1		
8. Place of Birth:	·		,
	aken – (Check box and enter da	ate of examination):	
- ( <u>3,967</u> )	NCCPA - Duesol.	+ manufacturoum	AND THE PROPERTY OF THE PROPER
	State Examination-Identify st	~	
	Other Examination specify; _	*	scort)
10. Basis for Vermont Certifica	tion – (Check box):	055	5630584
□ Apprenticeship Trained University Trained			
11. Do you have hospital privile Hospital Name(s) and Location		No	
12. In what year did you start w	orking as a physician assistant	t in Vermont?	
· '	practice in Vermont during the p		MYelson No
	nent of Health – Board of Medical Pra		

14. Other states where you now	v hold an active certification or license to practice:
15. States where you previousl	y were certified or licensed to practice:
16. Specialty: 6 G G	DEA Number: M H 0 195986
17. Name and office address of	
PPNNE, 23 Mansfield	evenue, Burlington, VT 05404 ( 128/0 kgs) An Ares
Name	Address Burlington, VT. 05404 (Suite 3
18. Please list (use additional s PRIMARY and SECONDARY S	heet if necessary) name(s) and address(es) of physicians who currently serve as your SUPERVISING PHYSICIAN(S). Attach signed sheets for each practice location.
Primary Supervising Physician(	s):
Name	Address
Secondary Supervising Physicia Name	an(s): Address
the most current delegation	Board of Medical Practice requires that you and your primary supervising physician(s) review agreement for your practice setting, paying attention to any additions or deletions in duties
PHYSICIAN sign it as well.	view, date and sign your delegation agreement and have your PRIMARY SUPERVISING Attach a copy of your signed delegation agreement to this application. This should be done and included with this renewal.
☐ Yes ☐ No 20. Please provide a letter from	your Supervising Physician attesting to the fact that you have practiced as a Physician
Assistant within the past two	
21. Continuing Medical Education	
NCCPA certified Physici     CME completion.	an Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of
b. For all others, an explan	ation of requirements and a CME Record form must be completed.
<ol> <li>Primary Supervising Physici returned with this application</li> </ol>	an and Second Supervisory Physician forms are provided. They must be completed and n.
	PART II
"Yes" answers to Questions 23	- 47 require an explanation on Form A.
23. Have you ever applied for a	nd been denied a certificate to practice medicine or any other healing art?
Vermont Departme	ent of Health – Board of Medical Practice – 2012-2014 Physician Assistant Licensure Renewal Page 2 of 19

AMADHILDRETZ.

″ '□ yes' <b>∀</b> r	no Anne HILDreth 055-00305824
· · · · · · · · · · · · · · · · · · ·	withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes 🍂 r	
25. Have you ever lieu of disciplinary	voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in action or any other reason?
□ yes ⇔	ho
26. Are any formal governmental auth national, state or lo	disciplinary charges pending or has any disciplinary action ever been taken against you by any nority, by any hospital or health care facility, or by any professional medical association (international, ocal)?
□ yes 💢	no
27. Have you ever	been denied the privilege of taking an examination before any state medical examining board?
□yes <b>x</b> (n	
28. Have you ever	discontinued your education, training, or practice for a period of more than three months?
. □yes 🔀	no ·
29. Have you ever	been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes □ \$	
30. Have you ever reduced, suspende you?	had staff privileges, employment or appointment in a hospital or other health care institution denied, ed or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against
□ yes o≪n	10
31. Has your privile restricted by, or sur	ege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or rendered to any jurisdiction or federal agency at any time?
□ yes         yes 32. Do you currentl prescribing you wou	no ly or have you ever prescribed any prescription medication over the internet? This does not include uld do using electronic medical records in your practice.
□yes ⇔	to the state of th
33. Are you present	tly or have you ever been a defendant in a criminal proceeding?
□ yes 🏋n	10
	PART III
(Unless other	wise ordered by a court, your responses to the questions in Part III are considered exempt from public
Any "yes" response	disclosure.) e to the questions below must be fully explained on the enclosed Form A.
34. To your knowled charged as of the d	dge, are you the subject of an investigation by any other licensing board under which you have not been late of this application?

- 34 ch
- 35. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

The following definitions are provided to assist you in answering questions 36 through 38.

"Ability to practice medicine" - This term includes:

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

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

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 Vermont Department of Health - Board of Medical Practice - 2012-2014 Physician Assistant Licensure Renewal

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.

36. 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?

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.

37. 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?

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.

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

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, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

## Part IV - Statutory Profile Questions

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 practitioner profile is located at the following website http://healthvermont.gov/hc/med\_board/profile\_search.aspx.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 39 through 44 have changed since your last application. We cannot process your application without them.

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

X₁ Check here if none

ONNEHIUPTOTA OSSOB30584

	for each matter.				
	(Conviction Date)	(Court)	(City/State)	(Crime)	•
0. N	lolo Contendere/Matters C	Continued [See 26 VSA	§ 1368(a)(2)] 🖟 Chec	k here if none	
	sufficient facts of guilt v	vere found and the mat	which you pleaded "nolo ter was continued without ntation for each matter.	contendere" ("I will not co a finding by a court of com	ntest it") or whe petent jurisdiction
		· **			
	(Conviction Date)	(Court)	(City/State)	(Charge)	
I. V		iption of all formal charg		Check here if none usions, and orders of the B	oard of Medical
	(Date)		Disposition - Summary)	appeared.	
2. 🛦	,	•	r States [See 26 VSA § 13	368(a)(4)]	e comprehensive de la comp
	findings, conclusions, a those states. <b>Please p</b>	nd orders of such author rovide complete copie	orities, and final disposition es of documentation for e	JAN 24	ırts, if appealed 2012
÷		Licensing or Certificatio		y/State) (Nature of Charge	))
. R	estriction of Hospital Privi	leges [See 26 VSA § 1	368(a)(5)]	k here if none	
	Revocation/Involuntary				
	competence or charact	er and were issued by is (opportunity for hea	the hospital's governing b	f your hospital privileges the ody or any other official of ou. Please provide con	the hospital aff
	(Date) (Hosp	oital) (State) (	Nature of Restriction) (F	Reason for Restriction)	
	B. Other Restriction	ons Scheck here	if none		
	Please provide a descri	ption of all resignations	from, or non-renewal of, r	nedical staff membership c	r the restriction
	in that hospital. <b>Please</b>	provide complete cop	ement of, a pending discipli pies of documentation fo	nary case related to compe r each matter.	tence or charac

Page 5 of 19

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking

12-2014 Physician Assistant Licensure Renewal
ANNEHIINAM 065 0030584

	🗓 in s	re of Action) settlement on for Action)			(Action)		□ In lieu
11	Medical M	Taloractice Court	ludamenta/Se	j stiomonto	[See 26 VSA § 1368	2(0)(64)1	
<b></b>					[See 20 VSA 9 1300	o(a)(oA)]	
	Α.	<u>Judgments</u>	Check her	e if none			
		against you ar payment date)	nd all medical r in which a pay pies of docum	nalpractice ment was	e arbitration awards a awarded to a compl	otion of all medical malpracting ainst you within the past 1 aining party if not listed beloposition and, if possible, a	0 years (10 years from w. <b>Please provide</b>
		None reporte	d				
		□ Judgment	□ Arbitration	1			
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Agains	st You)
		□ Judgment	☐ Arbitration	l ĝ			
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Agains	st You)
	B.	Settlements	ズ Check her	e if none			
		years (10 year	s from paymer provide comp complaint for	it date) in i olete copi	which a payment was es of documentatio	alpractice claims against yo s awarded to a complaining n, to include final disposit	party if not listed
	÷	(Date)	(Court)	(State	) (A	mount of Settlement Agains	t You)
						Ÿ	,
		(Date)	(Court)	(State	) (A	mount of Settlement Agains	t You)
45.	Years of P	ractice [See 26	VSA § 1368(a	)(10)] <b>1</b> !	984		
	What mor	nth and year did	you start practi	cing as a	Physician Assistant?	June 1984	
46.	permission	ents/Teaching [ to have this info ng appointments,	rmation poster	d on the w	eb. (This form follow	#46 is optional. By answerings the statutory wording. Sinc	ng, you re granting e most appointments
	Α.	Appointments					•
			information at	out your a	appointments to med	ical school or professional s	chool faculties.
		Dartmouth					
	•	Hanover NH		Σ Z			

Vermont Department of Health – Board of Medical Practice – 2012-2014 Physician Assistant Licensure Renewal Page 6 of 19

1	Adjuinct Faculty	Hone Hi	DRETH	0550	1030-
	200				1030S
	Franklin Pr (School) (City)	erco PAC Pros. (State) (Nature of Appointm	<del></del>	ar) To (year)	2010-
	(School) (City)	(State) (Nature of Appointm	nent) From (ye	ar) To (year)	
	B. <u>Teaching</u>				
	Please provide information past 10 years.	on regarding your responsibility Ctoへのいんとから	for teaching gradu	ate medical edu	cation within the
•		(State) (Nature of Tea		2 <u>(57.0 - 2.0</u> m (year) To (yea	<u>)</u> /
47.	Publications [See 26 VSA § 136	8(a)(13)]			
	Note: Answering #47 is optional. web. Please provide information years.	By answering, you are granting regarding your publications in p	permission to have beer-reviewed med	e this information ical literature wit	n posted on the hin the past 10
	None reported				,
		(Publication)	(	Year)	(Title
		<b>6</b>			_ (Title
48.	Activities [See 26 VSA § 1368(a	(Publication) )(14)]	(	Year)	<del></del>
	Note: Answering #48 is optional. web. Please provide information	By answering, you are granting regarding your professional or o	permission to have community service	e this informatior activities and av	n posted on the vards.
	None reported				
	-	(Activities or Awards)			
19. <u>Pr</u>	actice Setting [See 26 VSA § 1368	3(a)(15)]			
	What is the location of your prima West. Lebox	ary practice setting? のり、しその379	34		
	Town/City, State	* )		-	
50. <u>Tr</u>	anslating Services [See 26 VSA §	1368(a)(16)]	. •		
	Please identify any translating ser Are any translating services available.			No	
	If yes, please describe the transla	ating services available:	None		
51. <u>Me</u>	edicaid/New Patients [See 26 VSA	§ 1368(a)(17)]			
	A. <u>Medicaid participation</u>	, , , , , , , , , , , , , , , , , , ,			

Vermont Department of Health – Board of Medical Practice – 201Σ-2014 Physician Assistant Licensure Renewal Page 7 of 19

Are you currently accepting new Medicaid patients?	Yes □ No
Part V	
I hereby affirm that the information provided above is true and accumy knowledge an	rate, and that I have answered the questions to the best of dability.
Date: 11   11   11   Applicant's Signature	1010 Bac

New Medicaid Patients

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

4

### 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:_	One Wilco	
Date:	mili	

# Vermont Department of Health - Board of Medical Practice

# APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer questions 1 and 2

	Regarding Child Support
person suppor or liabi approv	5 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the n 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 rt order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; illity 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 wed by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would e 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".
person returns	Regarding Taxes  2 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the a 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 is 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 ensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You <u>must</u> 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".
Social S	Security #* Date of Birt
The di	lisclosure 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 partment of Taxes in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.
	STATEMENT OF APPLICANT
certify nforma	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 ation or omission of information is unlawful and may jeopardize my license/certification/registration status.
3ignatu	ure of Applicant Date 11/11/1

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications w	vill be returned. Attach additi	onal sheets as needed.
Name in full Theiler	Regan	Nell
Name in full <u>Theiler</u> (Last)	(Pirst)	(Middle)
Mailing Address Planned Pare	nthood of Norther, (Office Name)	n New England
183 St. Paul Street  Burlington, VT 0: (City State) (Z	(Ctroat)	Commence of the control of the contr
Burlington VT 0:	5401	02-863-6326
(City State) (Z	Cip Code) (	Telephone Number)
Vermont License #: <u>042-001226</u> 4		
Hospital(s) where you have privileges:  Fletcher Allen Health	Hospital(s) Loca h Care   11   Colche Burling br	ation Specialty Ster Ave. OB\GYN 1,VT
	05401	
What arrangements have you made for a 24/7 on call service	supervision when you are not	available or out of town:
CERTIFICATE	OF SUPERVISING PHYS	ICIAN
I hereby certify that, in accordance with 26 VSA of Anne Hidreth P.A outlining the scope of practice, attached to this a further certify that notice will be posted that a p. Section 1741.	<ul> <li>while under my supervision. I fu application, does not exceed the no</li> </ul>	urther certify that the protocol
I further certify that I have read the statutes and (Date)	( ·	
	(Signature of Supervising	- APPROXIMATION OF THE PROPERTY OF THE PROPERT
Co	-signature of PA: Opne H	yar,
Note: A PA who prescribes controlled drugs mu	.,	

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.							
Name in full Novello	Renee	·	<i>T</i> .				
(Last)	(First)	(	Middle)				
Mailing Address Planned F	f. I de transition of the contract of the cont	Sorthern New	England				
6 Robert	-5 North						
Rutland, VT (City/State)	(Street) 05 701 - 312.0	802-775-2	333				
(City/State)	(Zip Code)	(Telephone Nun	nber)				
Vermont License #: <u>042-001119</u>	75						
Hospital(s) where you have privilege Mt. Ascutney Hospital an Health Center	d 289 Cour	) Location S 1 ty Road 1	pecialty 28 GYN_				
List all physician's assistants names Amy Borgman, 90 Washi August Burns, 213 E.N Tohanna Hauser, 183 51	ington St. Barre VT.	05641 VET 16456					
CERTIFICATE OF S	SECONDARY SUPERVI	SING PHYSICIAN	Repair Paragraphic Control of the Co	POVEY			
I hereby certify that, in accordance with 26 of Anne Hildreth only when consulted by the aforesaid Physic practice, attached to this application, does no VSA, Chapter 31, Section 1741, the use of a	r.A. only when the primary sup- tian Assistant. I further certify the ot exceed the normal limits of m	ervising physician is una hat the protocol outlining	vailable and				
I further certify that I have read the statutes a	and Board rules governing physics (Signature of Secondary St	lll-					

Anne Hildreth, 90 Washington St., Barre, VT 05641. Sarah Vensel, 183 St. Paul St., Burlington, VT 05401 Tanet Young, 183 St. Paul St., Burlington, VT 05401





# Scope of Practice And Plan of Supervision at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's <u>Scope of Practice</u> for Physician Assistants consists of several documents:

- 1) <u>PPNNE Standing Orders</u>: Each P.A annually signs the <u>Standing Orders</u> that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A at PPNNE.
- 2) <u>Medical Oversight at PPNNE</u>: Please refer to the attached document, <u>Medical Oversight at PPNNE</u>, for information about the structure of supervision of P.A's at PPNNE.
- The Primary or Secondary Supervising Physician will have scheduled charts review for each Physician Assistant throughout the duration of their employment at PPNNE.
- 4) Additional information about PPNNE's health centers, patient population and P.A's at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with health centers in Vermont, Maine and New Hampshire. Under the supervision of PPNNE's Medical Director, P.A's at PPNNE health centers provide outpatient gynelogical and preventive care as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

As specified in Section I, Part I of the PPNNE <u>Medical Protocol</u>, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

Anne Hildreth

Regan Theiler M.D.

Supervising Physician

Date 12/2/11

Date

#### Personal Certification Record

Anne Sarver Hildreth

NCCPA Identification #: 1011311

Initial Certification Date: January 15,

1983

Expiration Date: December 31, 2011

You have completed all requirements for the 2009-2011 cycle. Your certification will be updated in December 2011.

You have outstanding requirements for the 2011-2013 cycle. Use the links below to learn more about how to maintain certification.

CME Info

Certified PAs must earn and log 100 CME hours, including 50 Category I hours.

Earning CME for the 2009-2011 cycle begins on 05/01/2009 and ends on 12/31/2011.

Earning CME for the 2011-2013 cycle begins on 05/01/2011 and ends on 12/31/2013.

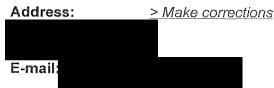
You have logged all required CME for the 2009-2011 cycle.

You have not logged all required hours for the 2011-2013 cycle.

> Log New CME

> View CME Summary

Your Contact Info



Fees & Payments

You do not have an outstanding balance for the 2009-2011 cycle.

Legai

You have answered 'no' to the three background questions. No further action will be required.

Important Dates & Deadlines

05/01/2011: First day to start earning CME for the 2011-2013 cycle.

06/30/2013: Last day to earn and log 2011-2013 CME hours and pay the discounted certification maintenance fee.

12/31/2013: Last day to fulfill any outstanding certification maintenance requirements for the 2011-2013 cycle.

Exam Notes

Certified PAs can take the recertification exam in the 5th or 6th years of their certification maintenance cycle.

Your 5th Year: 2012 Your 6th Year: 2013

Tools for Marketing Your Credential, click here for more information.

Not registered for a specialty Certificate of Added Qualification (CAQ) yet? <u>Click here</u> to learn how.

# Anne Hildroth DA

### 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] 800-745-7371 [fax] 802-657-4227

Date: January 17, 2012

Dear Physician Assistant:

Your 2012 Physician Assistant License renewal application has been received by this office and cannot be processed until the following information is received.

•			\$170 renewal fee						•			
Applicati	on Par	tl 🖂	. Hanna d			Item 21					Item 39	
		اسما	110117 1			Item 22					Item 40	
		<u></u>	Item 2	Part II			•		•		Item 41	
			Item 3			Item 23			***********		Item 42	
			Item 4			Item 24					Item 43A	
		. 📙	Item 5			Item 25					Item 43B	
			Item 6			Item 26					Item 44A	
			Item 7			Item 27					Item 44B	
		니	Item 8			Item 28					Item 45	
		. 4	Item-9			Item 29					Item 46A	
					Ц	Item 30			•		Item 46B	
			Item 11			Item 31					Item 47	
		<u></u>	Item 12	D. (11)		Item 32					Item 48	
			Item 13	Part III							Item 49	
		ليا	Item 14			Item 33					Item 50	
			Item 15			Item 34					Item 51A	
			Item 16			Item 35					Item 51B	
			Item 17			Item 36			Part V			
			Item 18	D + 11.7		Item 37					Date	
			Item 19	Part IV		H 00					Signature	
			Item 20		-	Item 38						
Child Su	opo	rt, Taxes	s, Unemployment Co	mpensation			Supervis	sing	Physician Fo	rms		
Statemer	ıt	······		<u>.</u>					Primary Su	pervi	sing Physician Ap <sub>l</sub>	plication
		<b></b>	Number 1 – check statements						Secondary Application		rvising Physician	
			Number 2 – check statements	one of the two					Delegation		ement	
							NCCPA	Cert	ification			
			eted form A eted Statement of Go	ood Standing					Proof of NC	CPA	Certification	
				1776								

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.

Enclosures



Renewal - 055.0030584 Page 1 of 11

#### Renewal - 055.0030584

Name	Anne Sarver Hildreth		
Credential	055.0030584		
Fee Details			
Renewal		\$170.00	
		\$170.00	

#### **Renewal Introduction**

VERMONT DEPARTMENT OF HEALTH BOARD OF MEDICAL PRACTICE PO BOX 70, Burlington, VT 05402 Phone: 802-657-4223 Fax:802-657-4227 Toll: 800-745-7371 www.healthvermont.gov

Physician Assistant License Renewal

This application includes your Physician Assistant License Renewal Application. Please follow the instructions below and submit the completed application with uploaded documentation and credit card payment. 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. Your licensure will lapse if we have not received your completed application and fee by the due date.

#### **INSTRUCTIONS**

You may download all forms that must be submitted to complete this application here.

- enter, correct, or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- provide explanations to "yes" answers in Parts II IV
- do not delegate this important task to any other person. False statements on this form may be grounds for charges of unprofessional conduct

#### Be sure to complete, submit or upload:

 completed application and appropriate attachments, e.g. Primary and Secondary Supervising Physician Applications, CME Form, NCCPA Certificate, Scope of Practice, etc.

Please send all appropriate documentation to the Board and submit the completed application, attachments and fee no later than January 15 to facilitate timely processing and avoid an interruption in your ability to practice because of a lapsed license.

#### Please Note:

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

1. Last Name:

Hildreth

2. First Name:

Anne

3. Middle Name:

Sarver

4. All other names used:

Previous Name	From Month	From Year	To Month	To Year	Reason for Change
			September	2012	

5. Enter your MAILING ADDRESS information:

Attention
Street
City
State
State
Country
United
States

E-mail Address
Telephone
Alternate Phone (e.g.
Pager)

6. Enter your PUBLIC ACCESS address information:

**Attention PPNNE** 

Street 128 Lakeside Avenue

City Burlington State VT Zip 05408

Country United States

Telephone

E-mail Address

Alternate Phone (e.g. Pager)

7. Date of Birth:



8. Birth City:



9. Birth State/Province:



- 10. Birth Country: United States
- 11. Select the certification examination taken (verification must be sent directly to this office from the Examining Agency):
  University Trained NCCPA Examination
- 12. Date NCCPA Examination was taken (if applicable): 12/18/2013
- 13. Date VT Apprenticeship Examination was taken (if applicable):
- 14. Basis for Vermont Certification: University Trained
- 15. Do you have hospital privileges in Vermont? No
- 16. List all hospitals where you have, or previously have had, privileges:

Facility Name State Start Date

- 17. In what year did you start working as a physician assistant in Vermont? 2012
- 18. Were you in active clinical practice in the past 12 months?
  Yes
- 19. Other states where you either now hold an active certification or license or previously were certified or licensed to practice:

- 20. Specialty: OB/GYN
- 21. DEA Number: MH0195986
- 22. Enter information for all Primary and Secondary Supervising Physicians. If you are to be supervised by a Doctor of Osteopathic Medicine please provide your response(s) in the next question. <a href="Enter ONLY">Enter ONLY</a> those supervisor(s) who ARE NOT Doctor(s) of Osteopathic Medicine here.

Supervisor	Relationship Type	Practice Location
042.0012264 : THEILER REGAN	Primary Supervising Professional	PPNNE
042.0011195 : NOVELLO RENEE	Secondary Supervising Professional	PPNNE

23. If you are to be supervised by a Doctor of Osteopathic Medicine, enter the information for those Primary and Secondary Supervising Physicians. Enter **ONLY** those supervisors who **ARE** Doctor(s) of Osteopathic Medicine here.

1 0 7		<del> </del>
DO Supervisor	Relationship Type	Practice Location

24. Has there been a change in your scope of practice which has not been reviewed by the Board?
No

#### **Continuing Medical Education (CME) Requirements**

- 25. NCCPA certified Physician Assistant: Upload proof of current NCCPA certification; this will serve as adequate proof of CME completion.
- 26. For all others, an explanation of requirements and a CME Record form must be completed and uploaded here.

Primary Supervising Physician and Second Supervisory Physician forms are available here. They must be completed and returned to the Board to complete this application.

#### Renewal Part II

## ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

27. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art?  No	
28. State:	
29. Year:	

- 30. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:
- 31. Denied certificate to practice medicine or any other healing art Upload documents
- 32. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art?

  No
- 33. State:
- 34. Year:

35. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:
36. Withdrawal or denial of license or certificate - Upload documents:
37. 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
38. State:
39. Year:
40. Circumstances:
41. Voluntary surrendered or resigned a license or certificate to practice medicine or any healing art - Upload documents:
42. 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
43. Name of organization involved:
44. Date:
45. Duration:
46. Action Taken (add all that apply):
47. Circumstances:
48. Disciplinary charges or actions - Upload documents:
49. Have you ever been denied the privilege of taking an examination before any state medical examining board?  No
50. State:
51. Circumstances under which examination privileges denied:
52. Denial of examination privileges - Upload documents:
53. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?  No
54. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:
55. Discontinued Education, Training, or Clinical Practice - Upload documents:
56. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?

57. Training program(s):
58. Location of program(s):
59. Year:
60. Circumstances:
61. 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
62. Institution involved:
63. Location:
64. Year:
65. Circumstances:
66. Affecting health care institution staff privileges, employment or appointment - Upload documents:
67. 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
68. Name of organization involved:
69. Type of restriction:
70. Date:
71. Circumstances:
72. Privilege to prescribe controlled substances - Upload documents:
73. 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
74. Please provide a general description of your practice of internet prescribing:
75. Are you presently, or have you ever been, a defendant in a criminal proceeding? No
76. Court:
77. City and state:

78. Charge:
79. Description:
80. Status:
Renewal 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.
81. 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?
82. Licensing or certification board:
83. Date:
84. Location of Licensing Board:
85. Circumstances:
86. Investigation by other licensing or certification board - proceeding - Upload documents
87. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?
88. Court:
89. City and state:
90. Charge:
91. Description:
92. Status:
93. Date:
94. Criminal Investigation - proceeding - Upload documents
MEDICAL QUESTIONS

Please answer "Yes" or "No" to the questions below. Definitions are provided to assist you in answering. Please explain any "Yes"

answers.

#### **DEFINITIONS**

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

- 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.
- 95. 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?



- 96. 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.
- 97. Please upload any documents you have that are relevant to this matter.
- 98. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs or potentially impairs your ability to practice medicine in your field of practice with reasonable skill and safety?



- 99. 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.
- 100. Please upload any documents you have that are relevant to this matter.
- 101. Are you currently engaged in the illegal use of controlled substances?



- 102. 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.
- 103. Please upload any documents you have that are relevant to this matter.

Renewal - 055.0030584 Page 8 of 11

#### **IMPORTANT**

Since 1999, part of each physician license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of practitioners affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call <u>802-223-0400</u> (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.

104. <u>Criminal Convictions</u> [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

105. <u>Criminal Convictions</u> [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

106. 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?

107. 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

108. 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

109. 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

110. <u>Licensing Authority Matters in Other States</u> [See 26 VSA § 1368(a)(4)]

Have there been any formal charges served against you by licensing or certification authorities of other states?

No

111. <u>Licensing Authority Matters in Other States</u> [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)]

112. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?

No

#### 113.

#### 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
---------------------	---------------	-------	-----------------------	------------------------

114. 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?

NΙΛ

115.

## 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

116. 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.

Nο

117.

#### 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

118

<u>B. Settlements</u> 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.** 

## 119. Years of Practice

What year did you start practicing as a medical professional? 1983

120. Hospital Privileges [See 26 VSA § 1368(a)(11)] List all hospitals where you currently have hospital staff privileges:

Facility Name City	y St	tate	Start Date	End Date
--------------------	------	------	------------	----------

# 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.)

121.

# A. Appointments

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

School	City	State	Nature of Position	Date Started	Date Ended
Dartmouth	Hanover	New Hampshire	Adjuinct Faculty		
Franklin Pierce University	Lebanon	New Hampshire	Perdieum Proctor	01/01/2010	01/01/2011

122.

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	Date Started	Date Ended
Frankling Pierce University	Lebanon	New Hampshire	Proctor	01/01/2010	01/01/2011

123. <u>Publications</u> [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 publication in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date

124. 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		
Activity of Award		

125. 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?
PPNNE	Burlington	Vermont	Yes		Yes	Yes

# **Statement of Good Standing**

126.

# 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

127. Date: 01/13/2014

## **Statement Regarding 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)

128. You <u>must</u> 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 <u>and payable and all returns have been filed</u>, 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)

129. 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.

130. Social Security Number:



131. Date of Birth:



132. 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

133. Date: 01/13/2014

### **Workforce Survey**

You must complete the workforce survey before you may complete your application to renew your license. The mandatory workforce survey is accessed by clicking here

134. I hereby certify that I have completed the workforce survey per the above instructions Yes

#### **Renewal Payment**

135. 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.

Credit Card

#### Review



# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

JAN 1 5 2014

Vermont Board of Anedical Practice

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Name in full	Burkett		Johna		•
	(Last)	. (	First)		(Middle)
Mailing Addr	ess Planned	Parenthood		INE	
128	Lakesida	Avo (Office)			
Burlie (City/S	ngton, VT State)	(Street) 	**	Who was a second of the second	48-971
Vermont Lice	mse #: <u>042,001</u> 23	, ,	,	(1 diophone	rvamber)
Hospital(s) w	here you have privil	-	lospital(s) L		Specialty
Fletcher What arrange	ments have you mad	e for supervision w	Burlingho	not available	ramily or out of tow
What arrange:  Strong r  OBJGN	ments have you mad clantion ship with the departments,	te for supervision work of the UVM + F	hen you are r AHC F	not available of	or out of tow
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# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.
Name in full Novello Renee
Mailing Address Planned Parenthood of NNE
128 Lakeside Ave, Suite 301
Burlington, VT 0540) 802-448-9719 (City/Smite) (Zip Code) (Telephone Number)
Vermont License #: 042-0011195
Hospital(s) where you have privileges:  Oartmouth Hitchcock  Labonon, NH  OB/GYN
List all physician's assistants names and addresses you currently supervise:  Amy Borgman 90 Washington St. Barre VT 05641  Erin Haynes 4 Bowdoin Mill Island St. 101, Topsham, ME 04081  Amy Corey. 80 Fairfield St. St. Albans, VT 05478  Jennifer Monarty-Lowen 24 Pannacook St. Manchester, NH 03104  CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN
I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Ane Hideh P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and hat in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.
further certify that I have read the statutes and Board rules governing physician assistants  (Signature of Secondary Supervising Physician)



# **Physician Assistant Delegation Agreement**

#### Narrative

Planned Parenthood of Northern New England is a non-profit health care organization with health centers in Vermont, Maine and New Hampshire. Under supervision of PPNNE's Medical Director, P.A.s at PPNNE health centers provide outpatient gynecological and preventive care.

# Supervision:

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol before function in an independent capacity. If further training in any expected area of competence is needed, this is arranged and takes place through on-line courses, live and recorded webinars and in-person trainings, including longitudinal proctoring, as needed.

The Medical Director, a board certified Family Practice MD, is the primary supervising physician, and provides oversight and supervision through on-site visits and consultations, telephone and written consultations and in-services. The secondary supervising physician is a board certified OB/GYN MD, and provides oversight and supervision in the same manner as the Medical Director. Medical back-up is available by telephone on a 24-hour basis. In addition, the Medical Director works with the Medical Clinical Quality Improvement Team and the Director of Quality and Risk Management to develop and review protocols, audits, and to evaluate any new developments in the medical field that may affect PPNNE.

All PPNNE mid-level practitioners practice under Medical Standards and Guidelines, as well as Standing Orders developed by the Medical Director. Practitioners attend continuing education in-service for medical training, discussion of protocol questions and other practice concerns, as well as attending outside CME conferences. In addition, we have community physicians who are available to our staff for consultation, telephone back-up and review of charts.

## Sites of Practice:

PPNNE's Physician Assistants see patients throughout Vermont, Maine and New Hampshire. Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

Each PPNNE site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinics as well as medical back-up arrangements with a physician or hospital.

## Tasks/Duties:

The Delegation Agreement for each Physician Assistant shall include problems and procedures typically encountered in the practice of Gynecological and Preventive care, which the PA has been trained to handle, and shall not exceed the normal scope of problems and procedures dealt with by the supervising physician(s) and must be in accordance with the policies of PPNNE.

There follows a list of tasks allowed to be included in the PA's Delegation Agreement which is intended to express a sense of involvement in the medical care and not intended to be a limiting one, except as specifically excluded by the Board of Medical Practice or by law. Participation in the practice of PPNNE's health centers shall include the performance of the following tasks:

- A. Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; midlife health; general preventive health care.
- B. Order and dispense hormonal contraceptives and HT/ET in accordance with PPNNE Medical Protocol. Manage routine hormonal contraceptive and HT/ET problems.

  Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.
- C. Insert and remove implant contraceptive systems in accordance with the PPNNE Medical Protocol. Manage routine implant system problems.
- D. Inject Medroxyprogesterone acetate in accordance with PPNNE Medical Protocol.



# **Physician Assistant Delegation Agreement**

Manage routine DMPA problems.

- E. Insert and remove IUD's in accordance with the PPNNE Medical Protocol. Manage routine IUD problems.
  - Order X-rays and sonograms for IUD localization.
- F. Fit and check diaphragms, cervical caps and other barrier devices in accordance with PPNNE Medical Protocol. Manage diaphragm, cervical cap and other barrier device problems.
- G. Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol. Manage condom and spermicide problems.
- H. Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, symptom-thermal, cervical mucus and calendar.
- I. Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and other tests indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
- J. Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.
- K. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
- L. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, and sonograms.
- M. Provide services to patient in the abortion, cervical dysplasia, infertility, male services and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
- N. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.
- O. Perform venipuncture; start and maintain I.V.'s.
- P. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- Q. Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.
- R. Where permissible by law, provide abortion services in accordance with the PPNNE Medical Protocol.
- S. Authorization to prescribe medications.
  - 1. The physician assistant named in this document will be authorized to prescribe medications in accordance with the Delegation Agreement submitted to and approved by the Vermont Board of Medical Practice.
  - 2. The physician assistant named in this document will be authorized to prescribe controlled drugs in accordance with the Delegation Agreement and approved by the Vermont Board of Medical Practice. A physician assistant who prescribes controlled drugs must obtain an identification number from the federal Drug Enforcement Agency (DEA).

MH1787956	
PA's VT DEA Number	

I have reviewed the above and acknowledge that these proposed activities do not exceed the scope of my current practice within Planned Parenthood of Northern New England, and that I will act as a principal supervising physician for the physician assistant named below, in their practice within this scope.

Anno Hildreth PA Print Name	Signature Sorres Milou	1/10/14 Date
Donna Burkett, MD	19 Budito	1-9-14
Collaborating Physician/Medical Director	Signature	Date



January 13, 2014

ATTENTION: Tracy Hayes

To Whom It May Concern:

The following score report for Anne Sarver Hildreth is provided for your information.

Exam: Physician Assistant National Recertifying Examination (PANRE)

Exam Date: December 18, 2013

**Score:** 434

Minimum Passing Score: 379

Pass/Fail Status: Pass

Anne Sarver Hildreth is currently certified by NCCPA and holds NCCPA identification number 1011311.

NCCPA identification number 1011311 will remain valid until December 31, 2015. This PA was initially certified on January 15, 1983. However, this PA may or may not have been continuously certified during this time frame.

Should you have any questions regarding the information provided in this report, please contact us at the number below. To receive information about NCCPA's certification requirements and policies, visit our Web site at www.nccpa.net or call 678.417.8100 to speak with one of our Information Service Representatives.

Sincerely,

Cindy NAIIS

Cindy Nalls

Manager of Certification Maintenance

P.S. You can verify the certification status of a PA by visiting our Web site at ww.nccpa.net.

The original version of this document includes

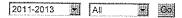
NCCPA's raised seal, affixed above.

# MY RECORD

Close Window

## 2011-2013

Anne Hildreth, your certification number 1011311 expires on 12/31/2015.



Cycle	Credits	Category	Date	Program Title	Provider	Sponsor	View
			04/29/2013 -	NAF conference, 37th	American Academy of	Openio in a 1923 de Servicio de enconocensione. I	aces on some of the some
2011-2013	7.00	1	04/30/2013	annual meeting	Family Physicians	AAFP	
				National Reproductive	University of		
	:		08/05/2012 -	Health conference - Title	Missouri-Kansas City		
2011-2013	11.75	1	08/07/2012	X	School of Medicine	AMA	
					University of		
				Planned Parenthood	Vermont College of		
2011-2013	6.00	I	06/19/2012	Abortioin in - service	Medicine	AMA	
					University of		
			06/11/2013 -	Family medicine review	Vermont College of		
2011-2013	16.50	1	06/14/2013	course	Medicine	AMA	
				NAF , clinicians for	American Academy of		
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					University of		
			05/09/2012 -	Womens health	Vermont College of		
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				Clinical Preceptor for PA			
			06/10/2013 -	students at Franklin			
2011-2013	200.00	ĭ.	07/12/2013	Pierce university			
Total Credits	: 257.75			:	!		

When logging these credits, I certified that the information contained above is true and correct. I also acknowledged that it is my responsibility to provide valid supporting documentation for all of my Category I credits if requested.

Printing Tip: Adjust browser page setup to landscape to print this report.