I hersby apply for the renewal of my Livense AS

A Physician

for the acried from ___/_1/1/957

To 01/31/1989

under the provisions of Title

Chapron 23 26-I enclose the correct tee at follows\$ 100.00

V.S.A

IMPORTANTE YOU MUST SIGN THE REVERSE SIDE OF THIS CERTIFICATE OR YOUR LICENSE WILL NOT BE REMEMED

LYON EDD 6 MD

140 HOSPITAL DRIVE BENNINGTON

05201

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interest -

DURING THE PREVIOUS 2 YEARS, HAVE YOU: please circle either yes or no

Had any treatment for mental illness? Hed any convictions other than minor traffic violations? dad an addiction to or been treated for drug or alcohol abuse? Had another state deny or take action against your license? YEARNY

And any final unfavorable liability judgements or settlements? YES

Had any hospital priveleges denied, consitioned or revoked? Recently started practicing in VY? YES(NO) Specify Dates

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STATE OF VERMONT RENEWAL APPLICATION

I hereby apply for the renewal of my: Physician License

EDD G LYON MD

140 HOSPITAL DRIVE BENNINGTON VT

11/30/90

12/01/90 - 11/30/92

150.0

42-0006255

Current Expiration !

Renewal Period Covering | Renewal Fee | Lic/Cert #

Renewals postmarked after the expiration date must include a late fee of \$25.00

INFORMATION NEEDED

A YES REQUIRES AN EXPLANATION. DURING THE PREVIOUS 2 YEARS, HAVE YOU:

Had any illness or conditions which impaired your ability to function as a physician? Had any convictions other than for minor traffic violations? YES(No Had an addiction to or been treated for abuse of drugs or alcohol? Had any jurisdiction deny or take action against your license? YES Had any final liability judgments or settlements against you? YES NO Had any hospital privileges denied, conditioned or revoked? YES/NO Recently started practicing in Vermont? YES(NO) List all hospitals you currently hold hospital privileges or have held in the past two years: (give dates) Southwestern Vt. Medical Center 1978- present

ADDITIONAL QUALIFICATIONS FOR RENEWAL

A professional license may not be renewed unless the licensee certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved to the office of child support or agreed to by the parties; or, the licensing authority determines that immediate payment of support would impose an unreasonable hardship (15 V.S.A. § 795).

A professional license may not be renewed unless the licensee certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with the payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship (32 V.S.A. § 3113). The maximum penalty for perjury is fifteen years in prison, a \$10,000 fine, or both.

STATEMENT OF APPLICANT

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

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due the State of Vermont as of the date of this application.

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

Date 10/22/90 Signature Eld Fyon M

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



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





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

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/92 to 11/30/94. TWO YEAR RENEWAL FEE: \$205.

Enclose a check in the amount of \$205. made payable to the Vermont Board of Medical Practice.

42-0006255 A

Edd Gilbert Lyon MD

140 Hospital Drive Bennington VT 05201

lm	port	an	t:	

- Please print legibly or type your answers.
- Answer all questions (front and back of each page) completely-it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.
- Thank you for your cooperation.

SECTION I

1. Name: EDD G- LYON 2. Vermont License N	umber: 42- <u>0006</u> 25.
3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere:	
4. Home Address:	
City, State, Zip Code:	
5. Office Address: 640 HOSPITAL DR.	
City, State, Zip Code: RENNINGTON, VT. 0526 6. Daytime Telephone Number: Area Code: (802) 447-491	
7. Date of Birth: Month: 8. Place of Birth: 9. Sex: Male	Female
10. Licensing Examination Taken - Check: National Boards FLEX State Examination-Identify State: Other Examination Specify:	
11. Undergraduate Degree - Circle: B.A.) B.S. A.B. Other: Year of Gradu	ation: [969
Degree Granting Institution: HAMICTON COLLEGE Location:	
12. Medical Degree - Circle: (M.D.) Other: Year of Graduation:	
Degree Granting Medical School: ALBANY MED: COLLEGE Location:	ALBANY N.Y.
	GUADALAJARA, M



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

CONTINUESTERN VT.	MEDICAL CENTER	
	VINGTON, VT.	
14. Did you practice in Vermont during the	e past 12 months?YesNo	
	· ·	
15. Other states where you now hold an a	ictive license to practice.	
16. States where you previously were lice	nsed to practice: OKLAHOMA	· · · · · ·
17. Please list your specialty(ies) and indi Specialty(ies) & Subspecialty(ies)	cate if you are American specialty board certified in the American Specialty Board Certified (Yes	ose specialties or No)
(a) FAMILY PRACTICE	Yes No Year Certified/Rece	
(b)	Yes No Year Certified/Rece	rtified:/
(c) <u> </u>	Yes No Year Certified/Rece	ertified:/
18. Please list the postgraduate educatio	nal degrees that you have earned related to your pract City State Degree Year	ice:
(a) ALBANY MEDUAL COLLE	CE ALBANY N.V. MD 1975	5
(a) MUSTING TREBUIL COLLECTION	<u>0</u> c <u>11c21107</u> <u>-1007</u>	
(b)		· ·
Institution	Olly Clark	fear Complet
(a) UNIV. OF OKLA.	TULSA DKLA, FAMILY PRAC.	1978
	· .	· <u>· · · · · · · · · · · · · · · · · · </u>
(b)		
(c)		
SEC A "YES" ANSWER REC	TION II: PLEASE CHECK YES OR NO. DUIRES AN EXPLANATION ON THE ENCLOSED FO	RM A. C
medicine or to function as a student of r		
2. Have you ever had an organic illness student of medicine, resident or fellow?	which has impaired your ability to practice medicine of	r to functionza
,)	dant in any criminal proceeding other than minor traffic	

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

6. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? YES
7. Has any medical malpractice claim been made against you in the last ten years (whet filed in relation to the claim/complaint/demand for damages)?
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a medical staff after a complaint or peer review action has been initiated against you? YES NO
9. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art? NO
10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? YES NO
11. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? YES NO
12. Have you ever withdrawn an application for a medical license or been denied a medical license for any reason? YESNO
13. Have you ever been turned down for coverage by a malpractice insurance carrier?YESNO
14. Have you ever been notified as a responsible party of a Severity Level III quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? YES NO
15. To your knowledge, are you the subject of an investigation by any other licensing beard as of the data of this application?
16. Have you ever been dismissed or asked to leave from a residency training program(s) YES
SECTION III - TO BE COMPLETED ONLY BY PHYSICIANS PRACTICING IN VERMONT
1. Current Status (please check one): Active Retired* Other (please explain) *Note: If you are retired or are not practicing in Vermont, you need not complete SECTION III; however you must complete SECTION IV.
2. Postgraduate training in Vermont: Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? Yes No If you are in a Vermont program, are you a Resident Clinical Fellow Research Fellow? How many hours per typical week do you spend in this Vermont postgraduate training program? hrs./wk. in Vermont.
3. What is the date you started practicing medicine (excluding residency or fellowship training)? (Month/Year) 8 / 78
4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)? (Month/Year) / 7.8
5. Are you a staff physician involved exclusively in inpatient care or an emergency room setting?Yes'No



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

Instructions for completing the ne	xt portion: Please complete one	"site" section	for each locat	ion where you
practice. Be as detailed as possible.	Estimate if exact figures are not a	available.		-

1 Solo Practice 2 Group Practice 3 Community Health Center 4 Hospital Outpatient Clinic 5 Hospital Inpatient 6 HMO (Health Maintenance 7 Extended Care Facility 8 School/College Health 9 Occupational Health 10 Emergency Room		11 Teaching12 Other Specify		
3 Community Health Center 8 School/College Health 4 Hospital Outpatient Clinic 9 Occupational Health 5 Hospital Inpatient 10 Emergency Room		12 Other Specify		
4 Hospital Outpatient Clinic 9 Occupational Health 5 Hospital Inpatient 10 Emergency Room			/:	
5 Hospital Inpatient 10 Emergency Room				
5 Hospital Inpatient 10 Emergency Room			**	
	,	*		`.
6. Practice Site Number One			,	
Street Address: 140 HOSPITAL DR.			•	
Town: BENNINGTON Zip:	05301			
Please complete one full line for each specialty (example: p		practice at this	site.	
Mains and Employment	1 140-4	· · · · · · · · · · · · · · · · · · ·		Will you
week Setting this specialty be acceeding (See discontinued within patie	opt new the patients	in accept n y are Medicaid	ew the patients in this specialty are	accept ne Medicare patients
Specialty In direct codes on the next 12 months? this patient on (Yes or No)	specialty? funded by it or No) (Estimate if	in this	funded by Medicare? (Estimate if	in this
care Page 4.)	necessary.)	specialty		specialty?
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		000000000000000000000000000000000000000		
7. Practice Site Number Two Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra		RUTLA	ND Zip: 6576	۱ ۶
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra	ctice at this site.	t of Will you	What percent of	Will you
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra Hours per Employment Setting Will the practice of this specialty be	you pt new What percer the patients	t of Will you accept n	What percent of the patients in	Will you accept ne
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra Hours per week engaged In direct patient on patient patient on patient patient patient on (Yea or No)	you pt new inte in specialty? or No) What percer the patients this specialty? (Estimate If	t of Will you accept n Medicaid patients in this	What percent of the patients in this specialty are funded by Medicare? (Estimate if	Will you accept ne Medicare patients in this
Street Address: Complete one full line for each specialty that you practice of this specialty be discontinued within the next 12 months?	you pt new inte in specialty? or No) what percer the patients this specialty funded by M (Estimate if necessary.)	t of Will you accept n Medicaid? patients in this specialty	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept ner Medicare patients in this specialty?
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Street Address: Please complete one full line for each specialty that you pra Hours per week engaged in direct patient care Specialty Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	you pt new inte in specialty? or No) what percer the patients this specialty funded by M (Estimate if necessary.)	t of Will you accept n Medicaid? patients in this specialty	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept ner Medicare patients in this specialty?
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you provided in direct patient care patient care Specialty Specialty Specialty Street Address: 6 ROBERTS NORTH Hours per week engaged line for each specialty that you provided in direct codes on Page 4.) Will the practice of this specialty be discontinued within the next 12 months? (Yes or No) Yes ONECOLOGY 3 3 NO Yes	you pt new the patients in specialty? or No) What percent the patients this specialt funded by N (Estimate if necessary.)	t of Will you accept in Medicald patients in this specialty	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept ner Medicare patients in this specialty?
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra Hours per week engaged in direct petient care Page 4.) Will the practice of this specialty be discontinued within the next 12 months? (Yes or No) Yes or No)	you pt new into in specialty? or No) What percer the patients this specialt funded by N (Estimate if necessary.) For-profit	t of will you accept n Medicald patients in this specialty Nonprofit	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept ner Medicare patients in this specialty?
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra Hours per week engaged In direct patient care Page 4.) Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	you pt new into into in specialty? or No) What percer the patients this specialt funded by N (Estimate If necessary.) For-profit s site, even if the	will you accept n Medicald patients in this specialty Nonprofit service is not pr	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept ne Medicare patients in this specialty?
Street Address: 6 ROBERTS NORTH Please complete one full line for each specialty that you pra Hours per week engaged in direct patient care Page 4.) Will the practice of this specialty be discontinued within the next 12 months? (Yes or No) Yes or No)	you pt new interior in the patients or No) What percent the patients this special funded by N (Estimate If necessary.) For-profit s site, even if the Prenatal	will you accept in Medicald patients in this specialty Nonprofit service is not proficate	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept ne Medicare patients in this specialty?
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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF SIX

Street Address: Town: Please complet Specialty	Hours per week engaged in direct patient	Employment Setting (See codes on	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicald? (Estimate if necessary.)	Will you scept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept no Medicare patients in this specialty
14 A - A - A - A - A - A - A - A - A - A	DA 3	Page 4.)	No	YES	0	VES	. 0	YES
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SECTION IV: STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF SIX

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or, the licensing authority determines that immediate payment of support would impose an unreasonable hardship (15 V.S.A. § 795).

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship (32 V.S.A. § 3113). The maximum penalty for perjury is fifteen years in prison, a \$10,000 fine, or both.

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT
I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due as of the date of this application. OR
I hereby certify that I an NOT in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship" to the address below.
APPLICANT'S STATEMENT REGARDING TAXES
I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000 fine, or both)
OR
I hereby certify that I am <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" to the address below.
STATEMENT OF APPLICANT
I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary ac
Social Security Number
The disclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. §
405(c)(2)(C), and will be used by the Department of Taxes in the administration of Vermont tax laws, to identify
403(c)(2)(c)), and win be used by the bepartment of taken in the comment of ta
individuals affected by such laws.
Date: $10/9/92$ Signature:
Return the completed form and fee to: Vermont Board of Medical Practice
(Return envelope enclosed) 109 State Street
Montpelier, Vermont 05609-1106

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

IMPORTANT: Please be sure to write your license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of \$205.* in check or money order payable to the Vermont Board of Medical Practice. (Medical Board Renewal Fee: \$200. + Office of Professional Regulation (OPR) Fee: \$5.00 = \$205. OPR's \$5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

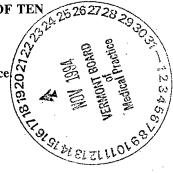
*Note: Physicians 80 years of age or older are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.

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

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/94 to 11/30/96. TWO YEAR RENEWAL FEE \$205.00.

Enclose a check in the amount of \$205.00 made payable to the Vermont Board of Medical Practice

Edd Gilbert Lyon 140 Hospital Drive Bennington, VT 05201



Important:

- Please print legibly or type your answers.

- Answer all questions completely it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.
- -Thank you for your cooperation.

SECTION I

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

	(Seedon recontains general	i initialization of initialization to do			•	
1.	Name: Lyon	, Edd	Gilber	<u>t</u>	•	
2.	Vermont License Number:	42-6255	M.2			
3.	Other Name(s), if any, under	er which you were licensed in	Vermont and elsewhere	since your las	t renewal:	,
						1.1
4.	Home Address: 140 Hospita	al-Drive			1	
	City, State, Zip Code: Benr	nington	, VT	05201		•
5.	Office Address:	10 Hospital)	<u> </u>			
					,	
	City, State, Zip Code:	Bennington	, vt. 0	5201		· · · · · · · · · · · · · · · · · · ·
No	ote: Circle either "Home Ao	ddress" or "Office Address"	as your preferred ma	ling address.		•
6.	. Daytime Telephone Number	er: <u>(802)447-1191</u>				
7.	. Date of Birth:		-			
8	. Place of Birth:	_		. <u></u>		
9	. Sex (M/F): M			•		

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

10. Licer	nsing Examination Taken - Check:N			_State Examination	on-Identify State	:
	<u> </u>	r Examination Specify		<u>·</u>		
11. Unde	ergraduate Degree: (B.A., B.S., etc.): BA	Ye	ar of Grad	uation: 1969		-
Majo	or Course of Study: Biology			• • • • • • • • • • • • • • • • • • • •		
Degr	ee Granting Institution: HAMILTON COL	LEGE				•
Loca	ntion: CLINTON	·, NY	USA			•
First	Institution (If transfer):			· · · · · · · · · · · · · · · · · · ·		
Loca	ation:				٠.	
12. Med	ical Degree: (M.D. or Other, please specif	y): <u>MD</u>	Yea	r of Graduation: 19	975	
Deg	ree Granting Medical School: ALBANY M	IEDICAL COLLEGE		· .		
Loca	ation: ALBANY	, NY	USA			
First	Medical School (If transfer): Unit	ersidad Avi	tomon	a de Guad	alajera	
	ation: Guadalajiva	Mexico			,	
13. Do ;	you have hospital privileges in Vermont?	Yes No		• .		·
	Southmestern VI.	Medical G	enter			1
	Bennin	aton vto			•	
· ·	·					
14. Did	you practice in Vermont during the past 1	2 months? Yes	No			٠
15. Oth	er states where you hold an active license	to practice:	7			
	es where you previously were licensed to	2	cla.			
17. Plea	ase list your specialty(ies) and indicate if y	ou are American Board	d of Medic	al Specialties certi	fied in those spe	ecialties:
r .	Constitute Codo(s)	American Board of Specialties Cert				,
	Specialty Code(s) ee the list of specialty codes.)	(Yes or No)	inica	Year Certified/Re	ecertified	,
(a)	601	Yes	•	[978]	1991	
(b)				1		
						
(c)						

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

(a) Postgraduate Degree: (Ph.D., etc.):	Year of Graduation:	
Major Course of Study:	<u> </u>	٠.
Degree Granting Institution:		•
Location:		
(b) Postgraduate Degree: (Ph.D., etc.):	Year of Graduation:	
Major Course of Study:		
Degree Granting Institution:		
Location:		
(c) Postgraduate Degree: (Ph.D., etc.):	Year of Graduation:	
Major Course of Study:	· ·	
Degree Granting Institution:		
Location:		

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

	titutions where you h		City	·	State _	Country	
Univ. o	f Okla		Tuls	~	Okla.	NIA	
Specialt		Year Completed					
6 0	<u>(</u>	1973					
I	nstitution		City		State _	Country	
				t			
Specialt	y Code t of specialty codes)	Year Completed					
· — · —							
·	nstitution	<u> </u>	City	· · ·	<u>State</u>	Country	
	ty Code st of specialty codes)	Year Completed	,				
<u> </u>							,
Ara you a prima	ry and/or secondary s	unervising phys	ician for a n	hvsician's	assistant (P.A	.)? Yes	
If yes, please lis	t:	apor romg puyo		Nurse A	wactioner	Check if:	•
Name of P.A.	Paul Grae	ther		, ,		Primary and/or Seco	nd
	and crae	TIVE					
, , , , , , , , , , , , , , , , , , , ,					· ·		

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

<i>j</i> .		•	SECI	HON I CONTINU	ED	•
21. Are you If yes,	u now in a c please list th	collaborative ne name(s) of	relationship with a nu	urse practitioner?	Yes	No
	٠,	Jee	previous			·
	. ,			7		×
	•				•	

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

SECTION I CONTINUED

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

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

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

During the past two years:

1.	Have you had any organic illness, emotional disturbance or mental illness which has impaired your or to function as a student of medicine, resident or fellow?	pility to pract	ice medicine
2.	Have you been a defendant in any criminal proceeding other than minor traffic offenses?	YES	<u>√</u> NO
3.	Are you currently under investigation for a criminal act?		
4.	Have you been dependent upon alcohol or drugs?		
5.	Are any formal disciplinary charges pending or has any disciplinary action been taken against you by authority, by any hospital or health care facility, or by any professional medical association (international)?	any governi onal, nationa YES	mental l, state or NO
6.	Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in reclaim/complaint/demand for damages)?		
7.	Have you had staff privileges, employment or appointment in a hospital or other health care institution suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a complaint or peer review action has been initiated against you?	on denied, re medical staf YES	duced, if after a NO
8	. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lie	u of disciplin YES	ary action?NO
9	. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, surrendered by any jurisdiction or federal agency at any time?	denied, restri	icted orNO
10). Have you been denied the right to participate or enroll in any system whereby a third party pays al	l or part of a	patient's bill?
1	1. Have you withdrawn an application for a medical license or been denied a medical license for any	reason? YES	√NO
1	2. Have you been turned down for coverage by a malpractice insurance carrier?	YES	NO
1	3. Have you been notified as a responsible party of a confirmed quality concern (quality of hospital or patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	eare provided YES	to Medicare NO
1	4. Have you been the subject of an investigation by any other licensing board?		

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

SECTION II CONTINUED

15. Have you been dismissed or asked to leave a residency training program(s) before completion?

YES

NO

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

Except for questions 1 and 4, "Yes" answers on past license renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1994-1996 period if the answer to any of the questions above changes from "No" to "Yes".

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

SECTION III

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

IMPORTANT:

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

	·
(1) APPLICANT'S STATEMENT REGAL	RDING CHILD SUPPORT (See Explanation Below)
compliance with a plan to pay any and all child support	OR
I hereby certify that I am <u>NOT</u> in good stand licensing authority determine that immediate payment of the address below.	ding with respect to child support due as of the date of this application and I hereby request that the of child support would impose an unreasonable hardship. Please forward an "Application for Hardship" to
(2) APPLICANT'S STATEMENT REGA	RDING TAXES (See Explanation Below)
taxes due to the State of Vermont as of the date of this	es of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000 fine, or both.) OR
I hereby certify that I am NOT in good stands that the licensing authority determine that immediate p	adding with respect to taxes due to the State of Vermont as of the date of this application and I hereby request ayment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship" to
the address below.	
(3) SOCIAL SECURITY NUMBER The disclosure of your social security number is ma Department of Taxes in the administration of Verm	and atory, is solicited by the authority granted by 42 U.S.C. \S 405(c)(2)(C), and will be used by the nont tax laws, to identify individuals affected by such laws.
(4) STATEMENT OF APPLICANT	
Failure to provide truthful and accurate information n	enewal application (including all pages and attachments) is true and accurate to the best of my knowledge. nay constitute grounds for deniallof license renewal or disciplinary action.
Date: Signature:	
Return the completed form and fee to: (Return envelope enclosed)	Vermont Board of Medical Practice 109 State Street Montpelier, Vermont 05609-1106
respect to or in full compliance with a plan to pay an	trade or business may not be renewed unless the licensee certifies that he or she is in good standing with y and all child support payable under a support order as of the date the application is filed. "Good standing" to obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial yment plan approved by the office of child support or agreed to by the parties; or, the licensing authority impose an unreasonable hardship (15 V.S.A. § 795).
A professional license or other authority to conduct a	trade or business may not be renewed unless the licensee certifies that he or she is in good standing with the

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

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

IMPORTANT: Please be sure to write your license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of \$205.00° in check or money order payable to the Vermont Board of Medical Practice. (Medical Board Renewal Fee: \$200.00 + Office of Professional Regulation (OPR) Fee: \$5.00 = \$205.00 OPR's \$5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

Department of Taxes. "Good Standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship (32 V.S.A. § 3113).

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

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

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SECTION IV

To be completed only by physicians practicing in Vermont.

SECTION IV

(Section IV is especially for the needs of health care access planning/physician recruitment and retention efforts in Vermont.) *Note: If you are retired or are not practicing in Vermont, do not complete Section IV. 1. Current Status (please check one): _____ Active _____ Retired* Other (please explain) 2. Postgraduate training in Vermont: (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? ___Yes ____No (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow? (c) How many hours per typical week do you spend in this Vermont postgraduate training program? hrs./wk. in Vermont. (d) What is the medical school that you are affiliated with for this training? University of Vermont Dartmouth Other (Please specify) 3. What is the date you started practicing medicine (excluding residency or fellowship training)? (Month/Year) $\frac{8}{2}$ / $\frac{7}{8}$ 4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)? (Month/Year) V / 785. Are you a staff physician involved exclusively in inpatient care or an emergency room setting? 6. What is your Unique Physician Identification Number (UPIN)? Instructions for completing this portion: Please complete a WORK SITE section for each practice and location where you provide patient care. For example, if your patient care is distributed in the following manner, you would complete four WORK SITE sections, one for each combination of practice and site: WORK SITE Section in this form Site **Practice** NUMBER ONE 126 Cherry St., Burlington Mountain Pediatrics **NUMBER TWO** City Hospital Pine St., Burlington NUMBER THREE Route 116, Hinesburg Mountain Pediatrics Route 7, Vergennes NUMBER FOUR Lakeview Pediatrics Be as detailed as possible. Estimate if exact figures are not available. Be sure to include the patient care that you provide in an inpatient setting. The codes to be used for the SPECIALTY column are enclosed on separate sheets.

SECTION IV CONTINUED

7(a). WORK S	ITE: <u>NUMBER ONE</u>		•
Name of Practic	ce(s): Penningfon Family	Practice ;	
Street Address:	140 HOSpital IV.		
Town:	Bouning ton (V)	Zip C	ode: <u>85201</u>
Is your practice Do you engage Do you engage Is your persona	at this site affiliated with an IPA HMO?You at this site affiliated with a Group/Staff HMO? in teaching at this site?YesNo in research at this site?YesNo all income from this practice site based on (checkFee for serviceCapitationCostThe codes to be used for the PRACT	NoNo as many as apply):	
	1 Solo Practice	7 Hospital Owned/Operated Office Practice	
	2 Group Practice: Single Specialty	8 Hospital Emergency Room	
	3 Group Practice: Multi-Specialty	9 Hospital Outpatient Clinic	
	4 FQHC/RHC Community Health Center	10 Hospital Inpatient	
	5 School or College Health Center	11 Extended Care Facility	
	6 Business or Worksite	12 Other: Specify	

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

`	SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new Medicaid patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
Γ	æ 601	40	2	Yes	Yes	No	YES
ſ	601	6-P	10	и,	18	ti.	11
ſ					1		
						<u> </u>	<u> </u>

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

	Service	Hours
	General pediatric medical care	85
1	General adolescent medical Care	45
/	General adult medical care	15
ン	General geriatric medical care	10
·	General gynecological medical care	-5
	General obstetric medical care	·

	TE: <u>NUMBER T</u>								
Name of Practice	(s): Be	ทกเ	ngton G	1/2	12				
Street Address: Fown:	Benning	ton	ngton G		<i></i>			Zip Co	ode: 05201
s your practice a s your practice a Do you engage in	t this site affiliate t this site affiliate teaching at this	ed with ed with site?	an IPA HMO? a a Group/Staff H Yes Yes No	Y6 MO ?	es Yes	No No			
s your personal Salary	income from this Fee for service	practi	ice site based on (cCapitation	heck _Cost	as many as based _	apply):Other (please sp	ecify)	
	The co	des to	be used for the PI	RACT	ICE SETTI	NG colum	n are as fo	ollows:	1
	1 Solo Practico	·	- · · · · · · · · · · · · · · · · · · ·		7 Hospi	tal Owned/	Operated	Office Practice	
	2 Group Pract	ce: Sii	ngle Specialty		8 Hospi	tal Emerge	ncy Roon	n .	
	3 Group Pract	ce: M	ulti-Specialty		9 Hospi	tal Outpati	ent Clinic		
,	4 FQHC/RHC	Comn	nunity Health Cent	er .	10 Hosp	ital Inpatie	nt ·		
	5 School or C	ollege	Health Center		11 Extended Care Facility				<u> </u>
•	6 Business or	Works	ite		12 Other	: Specify _		`]
Please complete	one full line for	each S	PECIALTY that Y	OU p	ractice at th	is site.			
SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours p week engaged in DIRECT PATIE CARE	NIT	Practice Setting (use codes provided above on this page)	conti pract speci next	ou plan to nue the ice of this alty for the 12 months? or NO	Will you ac patients in specialty? YES or NO	this	Will you accept new <u>Medicaid</u> patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
601	¥ :	3	5		762	Ye	7	761	No
			;		· · · · · ·				
Check the types service is not pr	of primary care	servio	ces that you perform	n at tl	nis site, and	the averag	ge hours p	er week of patier	nt care, even if the
•	. *		Service				Hours		
			General pediatr	ic me	dical care			_	•
		ļ	General adoleso	ent m	edical Care				
			General adult n	nedica	l care	<u> </u>	2	4	• • • • • • • • • • • • • • • • • • • •
•		<u> </u>	General geriatri				i	- (
١	*		General gyneco			are	1	-	٠.
	•	1	General obstetr	ic me	dical care		<u> </u>		

		•	N IV	CONTINU	JED			
7(c). WORK SI	TE: NUMBER THR	<u>EE</u>		i				
Name of Practice	(s):	nned Pa	rev	Mhoo	1		· · · -	
Succi Address		REBBY:75	Non	17h			Zip Co	ada:
	******	r V T			/		Zip Co	ode
Is your practice a	at this site affiliated wat this site affiliated w	vith an IPA HMO?	Y	es <u>l</u>	No /			
Is your practice a	nt this site affiliated w	vith a Group/Staff-H	MO?	Yes	No No		•	,
Do you engage ii Do you engage ii	n teaching at this site n research at this site	$\frac{1}{2}$? $\frac{1}{2}$ 1	o O				•	
•					• `			· .
Is your personal Salary	income from this pra_ Fee for service	actice site based on (o Capitation	check Cost	as many as based	apply): Other	(please spe	ecify)	
•	The codes	to be used for the P	RACT	ICE SETTI	NG colum	n are as fo	ollows:	٦ ·
· · ·	1 Solo Practice			7 Hospi	tal Owned	Operated	Office Practice	
•	2 Group Practice:	Single Specialty		8 Hospi	tal Emerge	ncy Room	1	
	3 Group Practice: Multi-Specialty 9 Hospital Outpatient Clinic						<u> </u>	
	4 FQHC/RHC Community Health Center 10 Hospital Inpatient							<u> </u>
	5 School or College	School or College Health Center 11 Extended Care Fa						
	6 Business or Wor	rksite		12 Other	r: Specify			
Please complete	one full line for each	SPECIALTY that Y	OU p	ractice at th	is site.			
SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	contin practi speci next	ou plan to nue the ice of this alty for the 12 months?	Will you ac patients in specialty? YES or NO	this	Will you accept new <u>Medicaid</u> patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
601.	3	. Ч		162	Yer	<u> </u>	762	. Nes
	. (· · ·		
		.)					×	, , , , , , , , , , , , , , , , , , , ,
	of primary care ser acticed as a specialty		m at th	nis site, and	the averag	ge hours p	er week of patier	nt care, even if the
:	, -	Service				Hours		
	1	General pediatr	ic med	dical care_		-		
١.		General adolesc	cent m	edical Care		7	<u> </u>	
	. ,	General adult n	nedica	l care	-			

SECTION IV CONTINUED

7(d). WORK SIT	E: <u>NUMBER FOU</u>	J <u>R</u>					,	
	(s):	- :						
Town:							Zip Co	ode:
Is your practice a Do you'engage in	t this site affiliated teaching at this si	with an IPA HMO? with a Group/Staff H te?YesN te?YesN	MO ?	es] Yes	No No			
Is your personalSalary	income from this prefer for service	ractice site based on (Capitation	check _Cost	as many as based	apply): Other	(please spe	ecify)	
	The code	s to be used for the P	RACT	ICE SETTI	NG colum	n are as fo	ollows:	
	1 Solo Practice			7 Hospi	tal Owned	Operated/	Office Practice	
	2 Group Practice	: Single Specialty		8 Hospi	tal Emerge	ncy Roon	<u> </u>	
·	3 Group Practice	: Multi-Specialty		9 Hospi	ital Outpati	ent Clinic		
	4 FQHC/RHC Co	ommunity Health Cen	ter	10 Hospital Inpatient				
*	5 School or Colle	ege Health Center		11 Extended Care Facility				
!	6 Business or W	orksite		12 Othe	r: Specify			
Please complete	one full line for eac	h SPECIALTY that Y	OU p	ractice at th	nis site.			
SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	<u> </u>	Practice Setting	Do y conti pract speci next	ou plan to nue the ice of this alty for the 12 months? or NO	Will you as patients in specialty?	this	Will you accept new <u>Medicaid</u> patients in this specialty? YES or NO	Will you accept new <u>Medicare</u> patients in this specialty? YES or NO
			,				, ,	
				· · ·				
1		<u> </u>	<u> </u>		<u>.</u>			<u> </u>
	of primary care se acticed as a specialt	ervices that you perfor y:	m at tl	his site, and	the averag	ge hours p	er week of patier	nt care, even if the
		Service				Hours		•
		General pediati	ic me	dical care			_	
		General adoles	cent_m	nedical Care	<u>. </u>			
		General adult r	nedica	l care			4	
		General geriatr	ic med	dical care	-		_	,
		General gyneco	ologica	al medical o	are			

General obstetric medical care

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

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/96 to 11/30/98. **TWO YEAR RENEWAL FEE:** \$300.00.

Enclose a check in the amount of \$300.00 made payable to the Vermont Board of Medical Practice.

EDD G. LYON 140 HOSPITAL DRIVE BENNINGTON, VT 05201

on Board

ledical Practice

Important:

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

SECTION I

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

1. Name: EDD GILBERT LYON				
2. Vermont License Number: <u>42-6255</u>				
3. Other Name(s), if any, under which you were licensed	in Vermont and	elsewhere sin	ce your last	renewal:
4. Home Address:				
City, State, Zip Code:		,		
5. Office Address: 140 HOSPITAL DRIVE	· · · · · · · · · · · · · · · · · · ·			
City, State, Zip Code: BENNINGTON, VT 05201				
Note: Circle either "Home Address" or "Office Addre	ess" as your pr	eferred mailii	ng address.	•
6. Daytime Telephone Number: (802)447-1191	· · · · · · · · · · · · · · · · · · ·			
7. Date of Birth:	_			
8. Sex (M/F): <u>M</u>		,		
9. Are you currently active in clinical practice in Vermor	nt? X Yes _	No		

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

10. Licensing Examination Taken - Check:National BoardsUSMLEOther B	FLEXState Examination-Identify State: r Examination Specify:
11. Undergraduate Degree: (B.A., B.S., etc.): BA	Year of Graduation: 1969
Major Course of Study: BIOLOGY	
Degree Granting Institution: HAMILTON COLLEGE	· · · · · · · · · · · · · · · · · · ·
Location: CLINTON, NY USA	
First Institution (If transfer):	· ·
Location:	· · · · · · · · · · · · · · · · · · ·
12. Medical Degree: (M.D. or Other, please specify): MD	
Degree Granting Medical School: ALBANY MED	SILAL LOLLEGE
Location: ALBANY, NY USA	
First Medical School (If transfer): UNIVERSIDAD AVI	
Location: <u>GUADALAJARA</u> , MEXICO	· · · · · · · · · · · · · · · · · · ·
13. Do you have hospital privileges in Vermont? ✓ Yes Name(s) and Location(s) of Hospital(s):	No
(a) SOUTHWESTERN VT. MEDICAL CENTER	• • • • • • • • • • • • • • • • • • •
(b)	· · · · · · · · · · · · · · · · · · ·
(c)	
(d)	
(e)	
14. Other states where you hold an active license to practice:	
	OKLAHOMA

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

SECTION I CONTINUED

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

	Specialty Code	Specialty Name		Board Certified ([Y]es/[N]o)	Year Certified/Recertified
(a)	0601	FAMILY PRACTICE		\ Y	1978 / 1496
(b)					1
(c)			•		

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

	Residency Institution #1	Residency Institution #2	Residency Institution #3
Institution			
Name	UNIVERSITY OF OKLAHOMA	·	
City	TULSA	·	
State	OK	•	
Country	USA		
Specialty			
Code	·		
(See list)	0601		
Specialty			
Name	FAMILY PRACTICE		
Year		1	
Residency			
Completed	1978		

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

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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

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

SECTION II: PLEASE CHECK YES OR NO.

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

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

During the past two years:

1. Have you had any organic illness, emotional disturbance or mental illness which has impaired your ability to practice medicine to function as a student of medicine, resident or fellow?	or
2. Have you been a defendant in any criminal proceeding other than minor traffic offenses? YES	
3. Are you currently under investigation for a criminal act?	
4 Have you been dependent upon alcohol or drugs?	
5. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any governmental author by any hospital or health care facility, or by any professional medical association (international, national, state or local)? YESNO	
6. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)?	
7. Have you had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, susper 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? YESNO	
8. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? YESNO)
9. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? YESYES	
10. Have you been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? YES	?
11. Have you withdrawn an application for a medical license or been denied a medical license for any reason? YES	Э
12. Have you been turned down for coverage by a malpractice insurance carrier? YESNO	Э
13. Have you been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	; O
14. Have you been the subject of an investigation by any other licensing board?	

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

SECTION II CONTINUED

15. Have you been dismissed or asked to leave a residency training program(s) before completion?

YES V

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

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

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

SECTION III

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

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

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or, the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1.	You must check one of the two statements below regarding child support regardless whether or not you have children:
	I hereby certify that as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
	or .
	I hereby certify that I am <u>NOT</u> in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".
•	Regarding Taxes
certifies the taxpa	§ 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person that he or she is in good standing with the Department of Taxes. "Good Standing" means that no taxes are due, the tax liability is on appeal, ayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You must check one of the two statements below:
	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	or
	I hereby certify that I am <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".
ť	

(continued on page 8)

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

SECTION III CONTINUED

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

	You <u>must</u> check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:
	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	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 to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an "Application for Hardship".
4.	* The disclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405(c)(2)(C), and will be use by the Department of Taxes and the Department of Employment and Training, in the administration of tax laws, to identify individuals affected by such laws, and by the Office of Child Support.
5.	STATEMENT OF APPLICANT
	I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary action. Date:
	Return the completed form and fee to: Vermont Board of Medical Practice (Return envelope enclosed) 109 State Street
<u></u>	(Return envelope enclosed) 109 State Street Montpelier, Vermont 05609-1106

OUESTIONS?: (802) 828-2673

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

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

(Month/Year) 08/1978

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

(Section IV is especially for the needs of health care access planning/physician recruitment and retention efforts in Vermont) 1. (a) Check all of the activities that describe your current status as a physician: ✓ Active in clinical practice in Vermont Active in clinical practice outside Vermont Administration ✓ Teaching Research ___ Retired Other (b) How many hours per week do you spend on administration, teaching and research? _____hours 2. Postgraduate training in Vermont: (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? Yes _√No Note: If you answered YES, please answer questions (b) and (c) (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow? (c) What is the medical school that you are affiliated with for this training? ___University of Vermont ___Dartmouth ___Other (Please specify) *** Note: If you are providing patient care in Vermont, **CONTINUE**. Otherwise, STOP and return this survey with your relicensing application. 3. What is the date you started practicing medicine (excluding residency or fellowship training)? (Month/Year) <u>08/1978</u> 4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?

5. Do you plan to retire or reduce your patient care hours in the next 12 months? ___Yes _____No

Instructions for completing this portion:

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

Γown: BENNINGTON			Coun	ty: <u>BENN</u>	NGTON			
*Note: Enter the town and county in	n which the si	te is located, not	a mailing a	ddress or P	ost Office box	.) .		•
Check the ONE practice setting from	n the selection		st accurately SETTING		our practice at	this site:		
Solo Practice				•	gency Room	•		
✓ Group Practice				pital Inpat				
Community Health Cente		on-Hospital)			Facility / Nur	sing Home		
Hospital Outpatient Clini	c _.		Oth	er: Specify				
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	4	1						
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care services to adolescents (ages 1					o (primary car	ç,ı. 20 you p	ovide prim	,

Prenatal care only

Prenatal care and delivery

✓ No obstetrical services provided

Instructions for completing this portion:

- * Estimate if exact figures are not available.
- * Please complete a WORK SITE section for each location where you provide patient care.
- * Do <u>not</u> include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.

 * Be as detailed as possible * Use the enclosed yellow s * Do not remove any pages 	sheet to make		Specialty Code	and Specialty Nam	e columns.	
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Town: <u>BENNINGTON</u> (*Note: Enter the town and county in	which the s	ite is located, not a		ENNINGTON s or Post Office box	· · ·	
Check the ONE practice setting from	the selection	ns below that mos PRACTICE	t accurately refle SETTINGS	cts your practice at	this site:	
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Will you accept new Medicaid patie	ents at this sit	te?Yesl	No			
Will you accept new Medicare patie	ents at this si	te? Yesl	No			
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Instructions for completing this portion:

- * Estimate if exact figures are not available.
- * Please complete a WORK SITE section for each location where you provide patient care.
- * Do <u>not</u> include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
- * Be as detailed as possible.

site? _____Prenatal care and delivery

- * Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
- * Do not remove any pages from this document.

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Group Practice	•		Hospital Inpa		
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Hospital Outpatient Clini	С		Other: Specif	fy .	
School or College Health	Center			•	
Business or Work Site	•				
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N.	Specialty			-	Per
,	Code		Specia	alty Name '	Week
Primary Specialty at this Site	0601	FAMILY PRACT	TICE		3
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Other Specialty at this Site					
Do you plan to continue practice at Will you accept new patients at this			Yes No		
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Prenatal care only

✓ No obstetrical services provided

Instructions for completing this portion:

- * Estimate if exact figures are not available.
- * Please complete a WORK SITE section for <u>each location</u> where you provide patient care.
- * Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
- * Re as detailed as possible

* Use the enclosed yellow s * Do <u>not</u> remove any pages			nancy Code and	operate rame columns.	
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Hospital Outpatient Clinic			Other: Specif	` y	
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Prenatal care only

Prenatal care and delivery

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

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

Your Name:	EDO	1401A		Vermont Lice	ense Number: _	46-6133
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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 1996-1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 6) CONTINUED

Your Role (circle one):		•
01 Anesthesiologist	11 PGY 4	
02 Primary Care Physician	12 PGY 5	
03 Referring Physician	13 PGY 6	
04 Attending Physician	14 PGY 7	•
	15 Workmen's Compensation Evaluator	,
06 Surgeon;	16 Court Psychiatrist	
	17 On-Call Physician	
07 Fellow		
08 PGY 1	18 Group Practitioner/Partner	
09 PGY 2	19 Other: Specify	
10 PGY 3	20 Unknown	j.
•		,
Legal Representative (include na	ame, address and telephone number):	. '
5 Frack	Roman II T	
Name: S. Crocker	Deviniett 1	
- Paul France	La Calline Tro	
Firm: TWV Flam	k & Collins, Inc.	- :
Oca Tha	rch St. Ro. Box 1307	•
Bustin	gton, vf. 05402	
City, State, Zip:	1704 V-11 03 102	
	•	
Telephone Number: ()	658-2311	
	•	• *
Indicate Decision, Appeal, Settle		•
If a Court or Arbitration Panel hea	ard your case, indicate the following: /	•
Decision determined by (Check o	ne): Arbitration Par	el
Decision: Allegation T57	Mismissed Award:	·
If your case was appealed, indica	ite the following: Date Appeal Filed (Month, Day, Year)	/
Date Appeal Decided:/		
		
If your case was settled, indicate	the following:	•
Settlement amount naid on your	behalf:	•
Total settlement amount:		•
Total settlement amount:	Vear) / /	
Date of Settlement. (Month, Day,	1 Cary	, · · · · · · · · · · · · · · · · · · ·
Case dismissed against w	ou Against all defendants	
case distributed against ye		
Important: In addition to the al	pove information, please attach a copy of the compl	aint and final judgment.
actilement and release or other	r final disposition of the claim. This information car	he obtained from your
legal representative.	Timal disposition of the claim. Time information out	, bo obtained it out you
legal representative.		
Additional information, if any:		
Additional information, if any.		r
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Table I for Section A on the next page

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

DIAGNOSIS RELATED	Improper Treatment: Medication Related
D01 Delay in Diagnosis	T21 Failure to obtain informed consent/exceeding consent obtained
Failure to Diagnose:	T22 Failure to take adequate patient history
D02 Abdominal Problems (other than appendicitis or ulcer)	T23 Failure to diagnose drug related problem(s) (other than addiction)
D03 AIDS/AIDS Related Complex	T24 Failure to diagnose drug addiction
D04 Allergy	T25 Prescribing to a known addict
D05 Appendicitis	T26 Wrong medication ordered
D06 Arthritis '	T27 Wrong dose of medication ordered
D07 Bladder Problem	T28 Improper route of administration
D08 Bowel Problem .	T29 Drug side effect
D09 Breast Cancer	T30 Failure to prescribe
D10 Cancer (other than breast)	T31 Drug toxicity/overdose
D11 Cardiac Disorder/Illness/Problem (not myocardial infarction)	T32 Other Specify:
D12 Circulatory Problem D13 Diabetes	Improper Treatment: Mental Illness Related
D14 Fracture/Dislocation	T33 Failure to obtain informed consent/exceeding consent obtained
D15 Gall Bladder Disorder	T34 Failure to diagnose mental disorder/illness/problem
D16 Genetic Disorder	T35 Improper medication prescribed
D17 Hemorrhage	T36 Improper commitment
D18 Hernia	T37 Improper discharge
D19 Implanted Foreign Body	T38 Improper monitoring
D20 Infection	T39 Improper use of seclusion/restraints
D21 Kidney Disorder	T40 Suicide/Suicide attempt by inpatient
D22 Liver Disorder	T41 Suicide/Suicide attempt by outpatient
D23 Meningitis	T42 Other Specify:
D24 Myocardial Infarction	· · · · · · · · · · · · · · · · · · ·
D25 Neurological Disorder	Improper Treatment: Obstetrics-Gynecology Related
D26 Orthopaedic Problem (other than fracture/dislocation)	T43 Failure to obtain informed consent/exceeding consent obtained
D27 Pneumonia/Pneumothorax	T44 Failure to diagnose pregnancy, normal
D28 Poisoning	T45 Failure to diagnose pregnancy related problem T46 Failure to diagnose ectopic pregnancy
D29 Respiratory Problem	T47 Failure to diagnose endometriosis
D30 Tendon Injury D31 Thrombosis	T48 Failure to diagnose fetal distress
D32 Turnor	T49 Failure to identify mother-fetus blood problem
D33 Ulcer or Complication(s) of Ulcer	T50 Improper performance of abortion
D34 Other Specify:	T51 Improper management of pregnancy
	T52 Improper management of delivery
D35 Failure to Obtain Consent for Diagnostic Procedures/Exceeding consent obtained	T53 Improperly performed vaginal delivery
D36 Misdiagnosis	T54 Improperly performed C-section
D37 Ordering/Performing Unnecessary Diagnostic Tests/Procedures	T55 Delay in performing C-section
D38 Failure to Perform Diagnostic Test(s)	T56 Delay in treating fetal distress
D39 Other Diagnosis Related Injury	T57. Failed sterilization
	T58 Wrongful life/birth
EQUIPMENT	T59 Fetal death/stillborn
E01 Equipment: Misuse	T60 Maternal death related to delivery
E02 Equipment: Malfunction	T61 Other Specify:
E03 Equipment: Other Specify:	Improper Treatment: Surgery Related
IMPROPER TREATMENT	T62 Failure to obtain informed consent/exceeding consent obtained
T01 Delay in Treatment	T63 Improper performance
T02 Failure to Obtain Informed Consent/Exceeding Consent Obtained	T64 Failure to diagnose post-operative complications
T03 Improper Choice of Treatment	T65 Improper treatment of post-operative complications
T04 Infection	T66 Retained foreign bodies (e.g. needle, sponge, instrument, etc.)
T05 Fracture/Dislocation	T67 Delay in surgery
T06 Chronic Vegetative State Resulting from Medical Intervention	· T68 Unnecessary surgery
	T69 Wrong body part
Improper Treatment: Anesthesia Related	T70 Laceration or penetration not within scope of surgery
T07 Failure to obtain informed consent/exceeding consent obtained	T71 Death in the course of/resulting from surgery
T08 Failure to take adequate patient history	T72 Other Specify:
T09 Failure to monitor	Improper Treatment: Specified Procedures
T10 Failure to test equipment/improper use of equipment	T73 Angiography
T11 Improper intubation	T74 Arteriography
T12 Improper positioning T13 Wrong amount/type of anesthesia prescribed	T75 CAT scan
T14 Allergic/adverse reaction	T76 Catheterization
T15 Teeth damage	T77 Colonoscopy
T16 Other Specify:	T78 Cryosurgery
	T79 Discogram
TRANSFUSION	T80 Electroconvulsive Therapy
TR17 Mismatch	T81 Endoscopy
TR18 Caused AIDS	T82 Esophageal Dilatations
TR19 Caused Hepatitis	T83 Injection/Immunization
TR20 Other Specify:	T84 Laparoscopy
	T85 Lasers, used in treatment

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

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

Court:	Charge:	Date:
Description:		
	· · · · · · · · · · · · · · · · · · ·	
	,	
J		
Status		
Conviction?:	Date:	
Status:	Date:	
SECTION C: DISCIPLINARY CHARGES OR A	ACTION (QUESTION 5) - ATTAC	H DOCUMENTS
Name of Organization Involved:		Date:
Ouration:		
Action Taken (circle all that apply): 01 Revocation of right or privilege 02 Suspension of right or privilege 03 Censure 04 Written reprimand or admonition 05 Restriction of right or privilege 06 Non-renewal of right or privilege 07 Fine 08 Required performance of public service 09 Education/Training/Counseling/Monitoring 10 Denial or right or privilege 11 Resignation Circumstances:	12 Leave of absence 13 Withdrawal of an applic 14 Termination or non-rend 15 Medical Records Suspect 16 Probation 17 Assurance of Discontinu 18 Consent Agreement 19 Letter of Agreement 20 Expulsion from Membe 21 Reprimand 22 Other Specify:	ewal of contract ension uance rship
SECTION D: PRIVILEGE TO PRESCRIBE COI		ESTION 9) - ATTACH DOCUMENT
Name of Organization Involved:		
Type of Restriction:	<u>.</u>	Date:
Circumstances of restriction:		
, · · · · · · · · · · · · · · · · · · ·	·	· · · · · · · · · · · · · · · · · · ·
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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 1996-1998 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE FIVE OF SIX

SECTION E: WITHDRAWAL OR DENIAL OF LICENSE (QUESTION 11) - ATTACH DOCUMENTS Year: Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated): SECTION F: INVESTIGATION BY ANY OTHER LICENSING BOARD (QUESTION 14) - ATTACH DOCUMENTS Name of Licensing Board: _____ Date: ____ Location of Licensing Board: ___ Circumstances: _ SECTION G: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED (QUESTION 15) - ATTACH DOCUMENTS Residency Training Program(s): Location of Program(s): Year: Circumstances: SECTION H: TREATMENT FOR EMOTIONAL DISTURBANCE OR MENTAL ILLNESS, ORGANIC ILLNESS, ALCOHOL OR DRUG DEPENDENCY (QUESTIONS 1 AND 4) Treating Organization: Telephone: (______) Person Responsible for Treatment: ____ Type of Condition and Treatment: Dates of Illness/Dependency: to _______to

Dates of Treatment: ______ to _____

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

nstitution Involved:			· •
Date:	· .	•	-,
Circumstance <u>s:</u>			·
SECTION J: VOLUNTARILY SURREND HEALING ART (QUESTION 8) - ATTAC	ERED OR RESIGNED A		
State:	Year:	· · · · · · · · · · · · · · · · · · ·	
Circumstances:	` `		1
	·		
SECTION K: DENIAL OF RIGHT TO I ATTACH DOCUMENTS Third Party Payer:		Year:	<u> </u>
ATTACH DOCUMENTS		Year:	
ATTACH DOCUMENTS Third Party Payer:		Year:	
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR COATTACH DOCUMENTS	OVERAGE BY MALPRA	Year:	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR CO	OVERAGE BY MALPRA	Year:	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR COATTACH DOCUMENTS	OVERAGE BY MALPRA	Year:	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR COATTACH DOCUMENTS Malpractice Insurance Carrier: Circumstances:	OVERAGE BY MALPRA	Year: CTICE INSURANCE CARE	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR COATTACH DOCUMENTS Malpractice Insurance Carrier:	OVERAGE BY MALPRA	Year: CTICE INSURANCE CARE	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR CONTACH DOCUMENTS Malpractice Insurance Carrier: Circumstances: SECTION M: CONFIRMED QUALITY CONTENT (QUESTION 13) ATTACH DOCUMENT	OVERAGE BY MALPRA	CTICE INSURANCE CARE Year: Year: EER REVIEW ORGANIZAT	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer:	OVERAGE BY MALPRA	Year:Year:Year:Year:Year:	RIER (QUESTION 12
ATTACH DOCUMENTS Third Party Payer: Circumstances: SECTION L: TURNED DOWN FOR CONTACH DOCUMENTS Malpractice Insurance Carrier: Circumstances: SECTION M: CONFIRMED QUALITY CONTENT (QUESTION 13) ATTACH DOCUMENT	OVERAGE BY MALPRA	Year:Year:Year:Year:Year:	RIER (QUESTION 12

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

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/98 to 11/30/2000. TWO YEAR RENEWAL FEE: \$300.

Enclose a check in the amount of \$300. made payable to the Vermont Board of Medical Practice.

Physicians 80 years of age or older or on full time active military duty (verification required) are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted? 13 LATE FEE: Late applications are assessed a \$25 late fee.

042-0006255

Edd Gilbert Lyon MD 140 Hospital Drive Bennington, VT 05201 Section of Bearing Section of Be

important:

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

CE.	\sim T	ION	ı

Name:	LYON	ENI	GILBERT	•	
	(Last)	(First) (Middle)	(Former)	
Vermont Lice	ense Number:	042-00	06255		
Other Name	(s), if any, under wh	ich you were licer	nsed in Vermont and else	ewhere since your last	
Mailing Add				140 Hospit	rac Di
Mailing Addr	ess	(Street)			
RENI	VINGTON ,	17.	D5201	802-447-0051 (Phone)	
(City)		(State)	(Zip Code)	(Phone)	
Office Addre	ess:	HOSPITA	C DR.	,	
_	INGTON ,	(Street)	05201	802-447-119	1
(City)		(State)	(Zip Code)	(Phone)	
Home Addre	ess:				
City, State,	Zin Code			i •	
Note: Circle website	your preferred mail	ng address. Plea	ase note that this addres	s will be public and listed on th	e Board's
Daytime Té	lephone Number A	rea Code: (<u></u> 80	2 , 447-1	191	<u>.</u> _

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

KLA.	DON'T KNOW	1 1975	FNACTIVE
State	License Number	Date Issued	Status (Active or Inactive)
Do you hold, section belov	or have you ever held, a med N.	dical license in any other stat	re? X Yes No If yes, complete t
. •	* * * * * * * * * * * * * * * * * * * *	OTHER LICENSES	A Section of the Sect
			,
· ·			The State of the Market Control
OUTHV	WESTERN VT	MED, CENTER	1978-PRESENT F. P.
ame	Address	From/To	
ist all hospit	als where you have, or previo	•	es. Include name, address, and dates.
=	hospital privileges?Y	Y	
		PRACTICE	
If ap	plicable, year recertified?		
Gubs	specially certificates.		
Subs	enocialty Certificate?		Year Certified?
If app	plicable, year recertified?	· · · · · · · · · · · · · · · · · · ·	
Spec	larty?		
	FAMILY	PRACTILE	Year Certified?:
Amer	rican Specialty Board Certified	d?No	
ibspecialty:_			
ecialty:	FAMILY PR	CHETTOC	· .
	FAMILIA DE	PACTICE	
		SPECIALTY	

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

SECTION II

SECTION II - "Yes" answers to Questions 1 - 24 require an explanation on the enclosed Form A.

Important note regarding the following questions: "Yes" answers on past renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1998-2000 period if the answer to any of the questions on the next two pages changes from "No" to "Yes". (Section II is for the reporting of information which is retained solely by the Board of Medical Practice and is not part of the data base maintained by the Department of Health.)

During	g the past two years:			
1.	Have you applied for and been denied a license to practice medicine or any healing art?	Yes _	X No	c
2.	Have you withdrawn an application for a license to practice medicine or any healing art?	Yes _	 N	lo
3.	Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lies	u of discipl	inary a	ction? o
4.	Are any formal disciplinary charges pending or has any disciplinary action been taken against you be authority, by any hospital or health care facility, or by any professional medical association (internat local)?	oy any gove tional, natio Yes _	onai, sta	ate or
5.	To your knowledge, are you the subject of an investigation by any other licensing board as of the d	ate of this	applica	ation?
6.	Have you been denied the privilege of taking an examination before any State Medical Examining	Board? Yes_	X _N	lo
7.	Have you discontinued your education, training, or practice for a period of more than three months'	? Yes _	<u>X</u> _N	lo
8.	Have you been dismissed or asked to leave a residency training program(s) before completion?	Yes	<u>_X</u> _ı	No
9.	Have you had staff privileges, employment or appointment in a hospital or other health care institut suspended or revoked; resigned from a medical staff in lieu of disciplinary action; or resigned from complaint or peer review action has been initiated against you?	a medicai	, reduc staff af	iter a
10.	Have you been denied the right to participate or enroll in any system whereby a third party pays all bill?	or part of	a patie	nt's No
11.	Have you been notified as a responsible party of a confirmed quality concern (quality of hospital ca Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	are provide Yes	d to X_I	No
12.	Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in claim/complaint/demand for damages)?	plation to th	10	
13.	Have you been turned down for coverage by a malpractice insurance carrier?	Yes	_X_	No
14.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoor surrendered by any jurisdiction or federal agency at any time?	ked, denie Yes	ed, rest	ricted No
15.	Have you been a defendant in any criminal proceeding other than minor traffic offenses (Note: DV Intoxicated - is NOT a minor offense)?	VI - Driving Yes	While	No
16.	To your knowledge, are you the subject of an investigation for a criminal act?			

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

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

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

- 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
- 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.
- "Chemical substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- "Currently", for purposes of this renewal application, does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
- "Illegal use of controlled substances" means the use of controlled substances obtained illegally as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner:
- Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If "yes," please explain.
- 18. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If "yes," please explain...
- 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,"
- 24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paragraph or any other psychotic disorder?

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE - SECTION III 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE FIVE OF FIVE

STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

Applicant's Statement Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1.	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 due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship". Applicant's Statement Regarding Taxes
unless th	Applicant's Statement Regulating Taxes 3 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You must check one of the two statements below:
×	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	or
·	I hereby certify that I am <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".
	Applicant's Statement Regarding Unemployment Compensation Contributions
busines or real e penaltie contribu is in goo paymen payable licensee	§ 1378 requires that: No agency of the state shall grant, issue or renewal any license or other authority to conduct a trade of sections (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and so 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 attitudes or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person code standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or its in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and 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 section and payable would be approved by the contributions due and payable would
	an unreasonable hardship. You <u>must</u> check one of the two statements below regarding unemployment contributions or payments in lieu of
3.	You must check one of the two statements below regarding discripioyment contributions
<u>×</u>	unemployment contributions: I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both).
·	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
* The dis Taxes as	Security: Date of Birth Date of Birth Sclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of the Department of Employment and Training, in the administration of tax laws, to identify individuals affected by such laws, and by the Office of Child Support. STATEMENT OF APPLICANT
I certify false in	y that the information stated by me in this application is true and accurate to the best of my knowledge. I understand that providing information or omission of information is unlawful and may jeopardize my license/certification/registration status.
Signat	ure of Applicant 200 July Date 10/5/93

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

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

Your Name: EDD	GILBERT	LYON	
MEDICAL MALPRACTICE CLAIR Please supply the following informa and filled out separately for each c	tion regarding each instanc	e of alleged malpractice: This form	should be photocopied
Insurer: PHCO			
Claimant Name: Racl	nel Middl	esteadt	· · · · · · · · · · · · · · · · · · ·
Description of Alleged Basis(es liability.) See Codes on TABLE	of Claim (Allegations O		admission of fault or
Basis Code: T U U	Basis Code:		
Basis Code:	Basis Code:		
Additional Descriptive Information 1) Patient's condition at point of you 2) Patient's condition at end of tre 3) The nature and extent of your is 4) Your degree of responsibility for	our involvement; atment; nvolvement with the patier	n leading to the claim.	
I did not en	er see th	is patient.	The Meive
care from	n our	practice the	ysilians
Assitant	and is	is patient. practice the sving the	practice
<u>a</u> a w	hole	U	
			,
	•		
			×
· ·			,
If the desired in potion	nt's doubth indicate cause	e of death according to autopsy	or patient chart:
<u>* *</u>			
Incident Location (circle one): 01 Emergency Room 05 Outpatient 09 HMO 13 Walk-In Center	02 Labor/Delivery 06 Patient Room 10 Clinic 14 Other	03 Laboratory/X-Ray/Testing 07 Hospital-Other 11 Nursing Home 15 Unknown	04 Operating Room 08 Hospital-Unknown 12 Physician's Office

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

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

Your Role (circle one):					
01 Anesthesiologist	11 PGY 4				
22 Primary Care Physician	12 PGY 5	`.			
3 Referring Physician	13 PGY 6	•	_		
04 Attending Physician	14 PGY 7				
05 Consultant Specialist	15 Workmen's Compe	ensation Evaluator	•		
06 Surgeon	16 Court Psychiatrist				
07 Fellow	17 On-Call Physician				
08 PGY 1	(18)Group Practitioner		*	•	
09 PGY 2	20 Unknown			6	
10 PGY 3	20 Officiown				
Legal Representative (include r	name address and teleni	hone number).			
			,		
Name: S CROCK	ER RENN	FTT		•	
			,	¥.\$	
Firm: Panl, Fro	ank, E Col	lins, Inc.			
Address: One Cl	muscla St.	PD ROX	1307	•	•
Address: UVC W	70010VC 01				
City, State, Zip: Burlin	ryton (1+-	05402			
822	(-b. 0) U7	· > -			
Telephone Number: (P32) <u>658 - 00-12</u>				
Indicate Decision, Appeal, Set	tloment Dismissal	•			
If a Court or Arbitration Panel he	ard your case indicate the	he following:	,		
Decision determined by (Check	oné): ludge	Jury Arbiti	ration Panel		
				•	
Decision:	Awa	rd:			
Decision	, ,,	,			
If your case was appealed, indic	ate the following: Date A	Appeal Filed (Month, D	Day, Year)		
Date Appeal Decided:	/ /·	, pp	, , , , , , , , , , , , , , , , , , ,		
Date Appeal Decided.					
If your case was settled, indicate	a the following	•	,		
ii your case was settled, indicate	s the following.		•		
Settlement amount paid on your	r hehalf:		•		
Settlement amount paid on your	Dellaii.				
Total settlement amount:					
Total settlement amount.					
Date of Settlement: (Month, Day	/ Year) /	/			
Date of Settlement. (Month, Da)	/, (car)				
Case dismissed against	yoù Against all d	defendants			
	ahawa befannasilan ola	nee attach a convic	of the complain	it and final judge	ment.
Important: In addition to the settlement and release, or othe	above information, pie	ase attach a copy of	ation can be ob	tained from your	legal
settlement and release, or other	er final disposition of the	e ciaim. This informa	ation can be ob	idiliod ii o iii y o iii	
representative.					
				•	
Additional information, if any	: 1				
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	i able I for Questi	on 12 on the next pa	រូម្ភិថ		

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

	Improper Treatment: Medication Related
DIAGNOSIS RELATED	T21 Failure to obtain informed consent/exceeding consent obtained
D01 Delay in Diagnosis	
Failure to Diagnose:	T22 Failure to take adequate patient history
D02 Abdominal Problems (other than appendicitis or ulcer)	T23 Failure to diagnose drug related problem(s) (other than addiction
D03 AIDS/AIDS Related Complex	T24 Failure to diagnose drug addiction
D04 Allergy	T25 Prescribing to a known addict
	T26 Wrong medication ordered
D05 Appendicitis	T27 Wrong dose of medication ordered
D06 Arthritis	
D07 Bladder Problem	T28 Improper route of administration
D08 Bowel Problem	T29 Drug side effect
D09 Breast Cancer	T30 Failure to prescribe
D10 Cancer (other than breast)	T31 Drug toxicity/overdose
D11 Cardiac Disorder/Illness/Problem (not myocardial infarction)	T32 Other Specify:
D12 Circulatory Problem	Improper Treatment: Mental Illness Related
D13 Diabetes	T33 Failure to obtain informed consent/exceeding consent obtained
D14 Fracture/Dislocation	T34 Failure to diagnose mental disorder/illness/problem
D15 Gall Bladder Disorder	134 Failure to diagnose mental disorderniness/problem
D16 Genetic Disorder	T35 Improper medication prescribed
D17 Hemorrhage	T36 Improper commitment
D18 Hernia	T37 Improper discharge
D19 Implanted Foreign Body	T38 Improper monitoring
	T39 Improper use of seclusion/restraints
D20 Infection	T40 Suicide/Suicide attempt by inpatient
D21 Kidney Disorder	T41 Suicide/Suicide attempt by outpatient
. D22 Liver Disorder	TAO Other Secrific
D23 Meningitis	T42 Other Specify:
D24 Myocardial Infarction	· · · · · · · · · · · · · · · · · · ·
D25 Neurological Disorder	Improper Treatment: Obstetrics-Gynecology Related
D26 Orthopaedic Problem (other than fracture/dislocation)	T43 Failure to obtain informed consent/exceeding consent obtained
	T44 Failure to diagnose pregnancy, normal
D27 Pneumonia/Pneumothorax	T45 Failure to diagnose pregnancy related problem
D28 Poisoning	T46 Failure to diagnose ectopic pregnancy
D29 Respiratory Problem '	
D30 Tendon Injury	T47 Failure to diagnose endometriosis
D31 Thrombosis	T48 Failure to diagnose fetal distress
D32 Tumor	T49 Failure to identify mother-fetus blood problem
D33 Ulcer or Complication(s) of Ulcer	T50 Improper performance of abortion
	T51 Improper management of pregnancy
D34 Other Specify:	T52 Improper management of delivery
Discouling control of the control of	
D35 Failure to Obtain Consent for Diagnostic Procedures/Exceeding consent obtained	T54 Improperly performed C-section
D36 Misdiagnosis	T55 Delay in performing C-section
D37 Ordering/Performing Unnecessary Diagnostic Tests/Procedures	
D38 Failure to Perform Diagnostic Test(s)	T56 Delay in treating fetal distress
D39 Other Diagnosis Related Injury	T57 Failed sterilization
See Guio, Singipole (Indiana)	T58 Wrongful life/birth
COLUMNET	T59 Fetal death/stillborn
EQUIPMENT	T60 Maternal death related to delivery
E01 Equipment: Misuse	T61 Other Specify:
E02 Equipment: Malfunction	To Fourier opeany:
E03 Equipment: Other Specify:	Improper Treatment: Surgery Related
	T62 Failure to obtain informed consent/exceeding consent obtained
IMPROPER TREATMENT .	162 Failure to obtain informed consentrexceeding consent obtained
T01 Delay in Treatment	* T63 Improper performance
T02 Failure to Obtain Informed Consent/Exceeding Consent Obtained	T64 Failure to diagnose post-operative complications
T03 Improper Choice of Treatment	T65 Improper treatment of post-operative complications
	T66 Retained foreign bodies (e.g. needle, sponge, instrument, etc.)
T04 Infection	T67 Delay in surgery
T05 Fracture/Dislocation	T68 Unnecessary surgery
T06 Chronic Vegetative State Resulting from Medical Intervention	T69 Wrong body part
•	
Improper Treatment: Anesthesia Related	T70 Laceration or penetration not within scope of surgery
T07-Failure to obtain informed consent/exceeding consent obtained	T71 Death in the course of/resulting from surgery
T08 Failure to take adequate patient history	T72 Other Specify:
Tog Failure to monitor	
T10 Failure to monitor T10 Failure to test equipment/improper use of equipment	Improper Treatment: Specified Procedures
	T73 Angiography
T11 Improper intubation	T74 Arteriography
T12 Improper positioning	T75 CAT scan
T13 Wrong amount/type of anesthesia prescribed	17.5 OZ1 300H
	T76 Call storization
T14 Allergic/adverse reaction	T76 Catheterization
T15 Teeth damage	T77 Colonoscopy
T16 Other Specify:	T78 Cryosurgery
1 to Galler opening.	T79 Discogram
TRANSFILEION	T80 Electroconvulsive Therapy
TRANSFUSION	T81 Endoscopy
TR17 Mismatch	T82 Esophageal Dilatations
TR18 Caused AIDS	
TR19 Caused Hepatitis	T83 Injection/Immunization
TR20 Other Specify:	T84 Laparoscopy
	TOE Lacore used in treatment

T86 Myelography

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

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

State:	Year:
Circumstances under which license was withdraw	vn or denied (revoked, not renewed, or otherwise terminated):
	·
	D A LICENSE TO PRACTICE MEDICINE OR ANY HEALING A
(QUESTION 3) - ATTACH DOCUMENTS	
State	Year:
State:	Year:
Circumstances:	
•	
	·
	•
DISCIPLINARY CHARGES OR ACTION (QUES	TION 4) - ATTACH DOCUMENTS
Name of Organization Involved:	Date:
Name of Organization involved.	Date:
Duration:	
Action Taken (circle all that apply):	12 Leave of absence
01 Revocation of right or privilege 02 Suspension of right or privilege	13 Withdrawal of an application
03 Censure	14 Termination or non-renewal of contract
04 Written reprimand or admonition	15 Medical Records Suspension
05 Restriction of right or privilege	16 Probation
06 Non-renewal of right or privilege	17 Assurance of Discontinuance
07 Fine	18 Consent Agreement
08 Required performance of public service	19 Letter of Agreement
09 Education/Training/Counseling/Monitoring	20 Expulsion from Membership
	21 Reprimand
10 Denial or right or privilege	22 Other Specify:
11 Resignation	22 Other openity.
Circumstances:	
:	·
•	
,	
INVESTIGATION BY ANY OTHER LICENSING	BOARD (QUESTION 5) - ATTACH DOCUMENTS
	,
Name of Licensing Board:	Date:
•	•
Location of Licensing Board:	
Circumatanaga	
Circumstances:	
•	
	·

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

DENIAL OF EXAMINATION PRIVILEGES (QUESTION 6) ATTACH DOCUMENTS State: Year: _____ Circumstances under which examination privileges denied: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED - DISCONTINUED EDUCATION, TRAINING, PRACTICE (QUESTIONS 7 & 8) - ATTACH DOCUMENTS Residency Training Program(s): ____ Year: _____ Location of Program(s): ___ Circumstances: _____ AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 9)- ATTACH DOCUMENTS Institution Involved: ______ Date: _____ Location: DENIAL OF RIGHT TO PARTICIPATE OR ENROLL - THIRD PARTY PAYER (QUESTION 10) ATTACH DOCUMENTS Third Party Payer: Year: CONFIRMED QUALITY CONCERN NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 11) ATTACH DOCUMENTS Location of PRO: Circumstances:

TO RESPOND TO QUESTION 12 SEE PAGE ONE OF THIS FORM

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

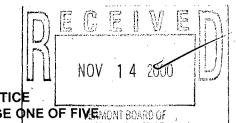
TURNED DOWN FOR COVERAGE BY MALPRACTICE INSURANCE CARRIER (QUESTION 13) ATTACH **DOCUMENTS** Malpractice Insurance Carrier: PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES (QUESTION 14) - ATTACH DOCUMENTS Name of Organization Involved: Type of Restriction: Date: Circumstances of restriction: CRIMINAL INVESTIGATION - PROCEEDING (QUESTIONS 15 AND 16) - ATTACH DOCUMENTS Court: CityandState:____ Charge: ___ Date: ______ Description: Status: ____ Conviction?: _____ Date: ____ Date: Plea?:

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

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

Treating Organization:				· .
Address:	•			
		•		
Telephone: ()				.*
Person Responsible for Treatment:				· · · · · · · · · · · · · · · · · · ·
Type of Diagnosis, Condition or Treatment - Field				
Type of Blagnosis, Condition of Troutinone Tiols	or, radioo		· ·	
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		-	<u>.</u>	·
Dates of Illness or Dependency:		to		
		1,		•
Dates of Treatment:		to		
Name and Location of Rehabilitation/Professional	· I Assistance c	or Monitoring Progra	am:	
1	•	·		
Telephone: ()		·	,	

Edd Gilbert Lyon 140 Hospital Dr. Bennington, VT



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

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/00 to 11/30/02. TWO YEAR RENEWAL FEE: \$350.00

Enclose a check in the amount of \$350.00 made payable to the Vermont Board of Medical Practice. Physicians 80 years of age or older or on full-time active military duty (verification required) are exempt from payment of a renewal fee; however, the physician license renewal application must be completed and submitted. LATE FEE: Applications post-marked or received after 11/30/00 are assessed a \$25.00 late fee.

042-0006255

Edd Gilbert Lyon MD 140 Hospital Drive Bennington, VT 05201

		TΑ	

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

SECTION I

Name:	LYON	EDI		
(Las	st)	(First)	(Middle)	(Former)
Vermont lice			ce your last renewal	ne(s), if any, under which you were
"MAILING A included.	ADDRESS	" will be public	and listed on the Board's v	website. All addresses must be
MAILING A	ODRESS:	(Street)	SPITAL DRIVE	
BENNIN	GTON	VT.	10520	802-447-1191
(City)		(State)	(Zip Code)	(Telephone)
OFFICE AD	DRESS:	SAME		
		(Street)	, ,	
(City)		(State)	(Zip Code)	(Telephone)
HOME ADD	DRESS:			
		(Street)		
. (City)		(State)	(Zip Code)	(Telephone)

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

oid you practice in Verr	in clinical practice in Venont during the past 12 in medicine without hosp	months?	Yes No Yes No Yes No	
		SPECIALTY	• • .	
Specialty:	FAMILY	PRACTIC	<u>.</u> €	
Subspecialty:			· · · · · · · · · · · · · · · · · · ·	· ·
American Specialty Boa	ard Certified:	 Yes	No	
Specialty:	FAMILY	PRACTICE	Year Certified:	1978
If applicable, ye	ear recertified:	1996		
jain sa				
		PRACTICE		
o you have hospital p	rivileges?	Yes	No ′	
ist all hospitals where	you have, or previously	have had, staff privile	ges. Include full infor	mation.
Name .	Address	Dates/From-	To Specialty	/Subspecialty
SOUTHWESTERN	VT. MED. (ENTER 8/	78- PRESENT	FAMILY PRACTI
	PITAL DR. BENN		•	
				· · · · · · · · · · · · · · · · · · ·
	LICENSE IN	OTHER JURISDICTION	ONS	
Do you hold, or have y If yes, complete the se	rou ever held, a medical ection below.	license in any other st	ate? Yes	s <u>X</u> No
State	License Number	Date Issued	Status (Active, In	active, Other)

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

SECTION III: "Yes" answers to Questions 1 - 24 require an explanation on the enclosed Form A. Important note regarding the following questions: "Yes" answers on past renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, indicate that on Form A. YOU HAVE A CONTINUING OBLIGATION TO UPDATE THE BOARD DURING THE 2000-2002 PERIOD IF THE ANSWER TO ANY OF THE QUESTIONS ON THE NEXT TWO PAGES CHANGE FROM "NO" TO "YES".

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

DURING THE PAST TWO YEARS:

		,
1.	. Have you ever applied for and been denied a license to practice medicine or any healing art?	Yes X No
2.	. Have you ever withdrawn an application for a license to practice medicine or any healing art?	Yes X No
3.	. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action?	Yes X No
4.	. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	Yes X No
5	To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?	
6	6. Have you ever been denied the privilege of taking an examination before any State Medical Examining Board?	Yes <u>X</u> No
, 7	7: Have you ever discontinued your education, training, or practice for a period of more than three months?	Yes <u>X</u> No
8	Have you ever been dismissed, suspended, or asked to leave a residency training program(s) before completion?	Yes 🗶 No
9	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 <u>X</u> No
1	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 <u> </u>
, 1	11. Have you ever been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patient) by the Peer Review Organization (PRO) in Vermont or elsewhere?	Yes 🗴 No
	12. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)?	
	13. Have you ever been turned down for coverage by a malpractice insurance carrier?	Yes_ <u>K</u> No
	14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted by or surrendered to any jurisdiction or federal agency at any time?	Yes X No
	15. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? (Note: Driving while intoxicated is <i>NOT</i> a minor offense.)	Yes <u>X_</u> No
	16. To your knowledge, are you the subject of an investigation for a criminal act?	

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

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

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

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

17. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, explain on Form A.

edicine with

- 18. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, explain on Form A.
- 19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because You receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, explain on Form A.
- 20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, explain on Form A.
- 21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionis or voyeurism? If yes, explain on Form A.
- 22. Are you currently engaged in the illegal use of controlled substances?
- 23. If yes to 22, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If yes, explain on Form A.
- 24. Have you been diagnoses with or have you been treated for bipolar disorder, schizophrenia, paranoia or any other psychotic disorder?



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE-PAGE FIVE OF FIVE SECTION IV

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

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1.	You <u>must</u> check one of the two statements below regarding child support regardless whether or not you have children:
<u>X</u>	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.
	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."
arandina	§ 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 with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the sioner of Taxes, or the licensing 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:
<u>X</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".
	Pegarding Unemployment Compensation Contributions
to, or endeclarate payment payment	§ 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) neter 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 tion, 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 is 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 its 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 tions 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 utring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.
3.	You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:
X	I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a 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 NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due
	to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
	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.
. —	I hereby certify that 21 V.S.A. § 1578 is not applicable to the occasion and not now, not have
Social	Security #* Date of Birth
Depar	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 treent of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such and by the Office of Child Support.
,	STATEMENT OF APPLICANT
l certif	by 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
inforn	nation is unlawful and may jeopardize my license/certification/registration status.
	Eld Ho
Signal	Date

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

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

Your Name:
MEDICAL MALPRACTICE CLAIM (QUESTION 12) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.
Insurer: ###################################
Claimant Name: RACHEL MIDDLESTEADT
Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.
Basis Code: Basis Code:
Basis Code: Basis Code:
Additional Descriptive Information - Please indicate: 1) Patient's condition at point of your involvement; 2) Patient's condition at end of treatment; 3) The nature and extent of your involvement with the patient; and 4) Your degree of responsibility for the course of treatment in leading to the claim.
2) Healthy
3) No personal contact with patient Person
involved in care of patient was physician's
Assistant working in our practice
4) Named in case as member of partner
practice
If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:
Incident Location (circle one): 01 Emergency Room 05 Outpatient 09 HMO 10 Clinic 11 Nursing Home 13 Walk-In Center 04 Operating Room 07 Hospital-Other 11 Nursing Home 12 Physician's Office

Question 12 continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED- 2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SEVEN

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

Your Role (circle one):			•
	1 PGY 4		
5	2 PGY 5	÷ .	
	3 PGY 6	•	
	4 PGY 7	7	
o i / illoinding i mjore	5 Workmen's Compensation Evaluator	•	
	6 Court Psychiatrist	•	
	7 On-Call Physician		
	8 Group Practitioner/Partner		
	9 Other: Specify	¥	
	0 Unknown	•	
Legal Representative (include name	e, address and telephone number):		
Name: Pan Fran	k é Collins elman		
Firm: David Spi	elman	· · · · · · · · · · · · · · · · · · ·	
Address: PD. BOX 13	307		€
City, State, Zip: Burling to	n, vt. 05402-130	7	•
	658-2311		,
Indicate Decision, Appeal, Settlem	lent, Dismissai:		
If a Court or Arbitration Panel heard	your case, indicate the following.	rhitration Panel	
Decision determined by (Check one)	: Judge Jury A		
Decision: Jettlement	Award:	-	
If your case was appealed, indicate Date Appeal Decided:/_	the following: Date Appeal Filed (Mont	h, Day, Year)	<u></u>
If your case was settled, indicate the	e following:		
Settlement amount paid on your beh	Branton & 11 06	<u> </u>	
Total settlement amount:	n		
Date of Settlement: (Month, Day, Ye	ear) 8 1 22 1 00		
Case dismissed against you	Against all defendants		•
Important: In addition to the abo settlement and release, or other fir representative.	ve information, please attach a cornal disposition of the claim. This info	by of the complaint a property of the complaint and the control of the complex of	and final judgment, ned from your legal
Additional information, if any:			
Case	settled before i	+ went	to
court by	agreement amon	ng car	ier and
plain tiff.		J	
\	Table I for Question 12 on the next	page	

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION PAGE THREE OF SEVEN TABLE I - BASIS CODES - QUESTION 12 - ALLEGATIONS ONLY

DIADORS RELATED OT Belly in Diagnosis Fallers to Diagnosis TOS ARDSANDS Related Compiles OX Based Forder OX Based Forders OX Based Frobers		•				
T2 Fallure to callange consentioneeding consent determined	DIA	SNOSIS RELATED		Improper Treatment: Medication Related		
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DOZ ANDRADO Researce Commerce DOS Appendicions				T22 Failure to take adequate patient history		
1003 All All Agricultures 1725 Failure to disponse drug addiction 1725 Presidency on a shrown addict 1725 Presidency of a shrown addition of the shrown and addition of the shrown addition of the shrown addition of the shrown and the shrown addition of the shrown addition of the shrown and the shrown addition of the				T23 Failure to diagnose drug-related problem(s) (other than addic	tion)	
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D13 Cardiacy Disposer/Problem D13 Disposers D15 Cardiacy Problem D16 Cardiacy Problem D17 Hemorrhage D18 Cardiacy Disorder D18 Cardiacy Disorder D19 Prepared Foreign Rody D19 Pre					. •	
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DI 3 Diabetes Improper Treatment: Mental Illiness Related Discrete Discrete Dis Baudet Discrete Dis Brightel Foreign Body Dis Hemin Dis Brightel Foreign Body Dis Implanted Foreign Body Distriction The Distriction Distriction The Distriction Dis			,	· · · · · · · · · · · · · · · · · · ·		
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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION PAGE FOUR OF SEVEN

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

tate:	Year:
rcumstances under which license was withdrawr	n or denied (revoked, not renewed, or otherwise terminated):
) A LICENSE TO PRACTICE MEDICINE OR ANY HEALING AF
RUESTION 3) - ATTACH DOCUMENTS	
tate:	Year:
· · ·	·
rcumstances:	
ISCIPLINARY CHARGES OR ACTION (QUEST	ION 4) - ATTACH DOCUMENTS
ame of Organization Involved:	Date:
uration:	
ction Taken (circle all that apply):	
1 Revocation of right or privilege	12 Leave of absence
2 Suspension of right or privilege	13 Withdrawal of an application
3 Censure	14 Termination or non-renewal of contract
4 Written reprimand or admonition	15 Medical Records Suspension
5 Restriction of right or privilege	16 Probation
6 Non-renewal of right or privilege	17 Assurance of Discontinuance
7 Fine	18 Consent Agreement
8 Required performance of public service	19 Letter of Agreement
9 Education/Training/Counseling/Monitoring	20 Expulsion from Membership
0 Denial or right or privilege	O4 Denrimond
1 Resignation	21 Reprimand 22 Other Specify:
(Teelghale)	
Circumstances:	
NVESTIGATION BY ANY OTHER LICENSING	BOARD (QUESTION 5) - ATTACH DOCUMENTS
Name of Licensing Board:	Date:
ocation of Licensing Board:	
Circumstances:	·
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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF SEVEN

DENIAL OF EXAMINATION PRIVILEGES (QUESTION 6) ATTACH DOCUMENTS Circumstances under which examination privileges denied: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED - DISCONTINUED EDUCATION, TRAINING, PRACTICE (QUESTIONS 7 & 8) - ATTACH DOCUMENTS Residency Training Program(s): Location of Program(s): ______ Year: _____ AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 9)- ATTACH DOCUMENTS Institution Involved: _____ Date: _____ Location: Circumstances: DENIAL OF RIGHT TO PARTICIPATE OR ENROLL - THIRD PARTY PAYER (QUESTION 10) ATTACH DOCUMENTS Third Party Payer: ____ Circumstances: CONFIRMED QUALITY CONCERN NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 11) ATTACH DOCUMENTS PRO: Year: _____ Location of PRO: Circumstances:

TO RESPOND TO QUESTION 12 SEE PAGE ONE OF THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF SEVEN

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

Malpractice Insurance Carrier:		Year:	
Circumstances:		-	, , , , , , , , , , , , , , , , , , , ,
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PRIVILEGE TO PRESCRIBE (CONTROLLED SUBSTANCES	(QUESTION 14) - ATTACH D	OCUMENTS
Name of Organization Involved	d:		
Type of Restriction:		Date:	
Circumstances of restriction:			<u> </u>
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Court:	PROCEEDING (QUESTIONS	15 AND 16) - ATTACH DOCU	
CityandState:			
Charge:			
Date:	· · · · · · · · · · · · · · · · · · ·		
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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A CONTINUED - 2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION PAGE SEVEN OF SEVEN

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

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Dates of Treatment:		to		
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Telephone: ()				
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Contact Person at Program:				

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Instructions

VERMONT DEPARTMENT OF HEALTH BOARD OF MEDICAL PRACTICE

2002 PHYSICIAN'S LICENSE RENEWAL APPLICATION

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

Please enclose a check in the amount of \$350 payable to the Vermont Department of Heath. Note: Physicians 80 years of age or older or on full-time active military duty (verification required) are exempt from payment of a renewal fee; however, the physician license renewal application must be completed and submitted. LATE FEE: Applications post-marked or received after 11/30/02 are assessed a \$25 late fee. Please print legibly or type your answers. Please type or print in block letters, one letter (or digit) in each box. Answer all questions completely; it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Parts II and III. Please be sure to write your name and license number on each attachment. Please be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions. Make a copy of the completed form and all attachments for your own records. Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct. Please return the document in its entirety at your earliest convenience. Your current license expires on November 30, 2002.
Part I - Identity Questions
Vermont Physician's License Number: 042-006255
1. Print your full name as you wish it to appear on the license:
First name: EDD
Middle name: GILBERT OCT 8 2002
Last name: LYDN
Extension: VERVICHT AGARD OF MEDICAL PRINCIPES
2. Have you ever legally changed your name? Yes No
Former name, or any other name under which you were licensed in Vermont
or elsewhere in the past two years:
3. Your date of birth: MMDDYYYYY
4: Your mailing address: (Check one: ☐ Home address ★ Work address)
Care of:
Street: 140 HOSPITAU DRIVE

Town/City: $ \beta \in N N \beta = N N N N N N N N N $
State: \sqrt{T}
Zip Code: 0 5 7 0 1 -
5. Your electronic addresses:
Home telephone (optional): example: 802-555-1212
Work telephone:
E-mail (optional):
6. Were you in active practice in Vermont in the past 12 Months?
7. Are you currently participating in residency or fellowship training Yes X No
8. Do you hold, or have you ever held, a medical license in any other state? X Yes No
If yes, complete the section below:
Date Issued
State License Number M M D D Y Y Y Y Status (Active, inactive, other)
DK 1975 INACTIVE
If necessary, please use an additional sheet and check this box:□
Part II - Licensure and Practice Questions Any "yes" response to the questions below must be fully explained on the enclosed Form A.
9. Have you ever applied for and been denied a license to practice medicine or any other healing art?
Yes No
10. Have you ever withdrawn an application for a license to practice medicine or any other healing art? Yes No
11. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
Yes No
12. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional
medical association (international, national, state or local)? Yes No
13. Have you ever been denied the privilege of taking an examination before any state medical
examining board? Yes No

14. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation?
Yes X No
15. Have you ever been dismissed or suspended from, or asked to leave a residency training program
before completion? Yes X No
16. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you? Yes No
17. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time? Yes No
18. Are you presently a defendant in a criminal proceeding? Yes No
Part III - Confidential Section
Part III is exempt from public disclosure
Any "yes" response to the questions below must be fully explained on the enclosed Form A.
19. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
20. 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 after the questions to assist you in answering. Please explain any "Yes" answers on Form A.
21. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?
In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.
22. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?
In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

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

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

- 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
- The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.
- "Currently" This term means recently enough to have a real or perceived impact on one's functioning as a licensee.
- "Chemical substances" This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- "Controlled substances" This term means those drugs listed on Schedules I through V of Section 202 of the
- Controlled Substances Act (21 USC § 812).
- "Illegal use of controlled substances" This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

Part IV - Statutory Profile Questions

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

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

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

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

Co M	nvic M	tion D	n Da D	ite Y	Y	Y	Y	Court	City		Sta	ıte	Crime		
				-											
	-													-	
				,					`	 					

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

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

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

Da	te											
M	M	D	D	Y	Y	Y	Y	Court	City	State	Charge	Nature of Action
												□ Nolo Contendere
												☐ Matter Continued
												□ Nolo Contendere
												☐ Matter Continued
												☐ Nolo Contendere
								V 100		May 162 Street		☐ Matter Continued

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

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

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

Da M	te M	D	D	Y	Y	Y	Y	Final Disposition (Summary)
			<u> </u>		Γ			
		-		,			, -	

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

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

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

Da M	te of	f Fin	nal . D	Disp	osi Y	tion Ý	Y	Licensing Authority	Court	City	Sta	ite	Nature of Charges
	-												

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

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

A. Revocation/Involuntary Restrictions

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

Da M		D	D	Ŷ	Y	Y	Y	Hospital	Si	ate	Nature of Restriction	Reason for Restriction
-	<u> </u>	-								1		
-						-						

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

B. Other Restrictions

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

Date M M	D	D	Ÿ	Y	Y	Y	Hospital	State	Nature of Action	Action	Reason for Action
	-4.2				re ·					☐ In Lieu of ☐ In Settlement	
										☐ In Lieu of ☐ In Settlement	
										☐ In Lieu of ☐ In Settlement	

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

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

A. Judgments

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

Da	te										Amount Assessed	
M	M	D	D	Y	Y	\mathbf{Y}^{\cdot}	Y	Court	State	Nature of Case	Against You	
				1	9	9	8	BENNINGTON JUPERIOR LOURT	VT	☐ Judgment	fil pood paid by carrier for entire practice - I was primary defende	
								3 7 7 6 10 10 1		△ Arbitration	practice - I was	not
1		1		Licenson						□ Judgment	primary defende	٠١/٠٤
										☐ Arbitration		
) <u> </u>	- ACIONALE	3 1000	Right College			- Charger				□ Judgment	1	
										☐ Arbitration.		,

B. Settlements

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

Da M	te M	D,	D	Y	Y	Y	Y	Court	Sta	Amount of Settlement Against You
Ņ										
<u>:</u>		-						. ,	1	

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

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

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

		/			Ye	ar o	f	
School	City		Sta	te	Gra	idua	tior	1
Universidad Autonoma de Buad.	Condalniava	Mexico	M	X				
Albany Medical College	Alban,		N	4	ſ	9	7	5
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		. ,						

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

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

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

School/Institution	Specialty		City	Sta	te		ar o adua	f ation	1
UNIV. OF DICIA.	FAMILY	PPACTICE	TULS 4	D	ic)	9	7	P
`			·		;	<u> </u>		,	Ŀ
									<u> </u>

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

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

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		X ves □ r	o Am. Board of F.P.	1978	1997
		□ ves □ r	0		
•		□ ves □ r	0		

33	Years of Practice	[See 26 VSA	Ş	1368(a)(10)]
·	I cars of I ractice	[500 20 .5.1	J	

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

M	M	Y	Y	Y	Y
0	8	[9	7	R

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

List all hospitals where you currently have hospital staff privileges:

Name	City		Sta	te	Ye	ar S	tarte	ed
SOUTHWESTERN VT. MED. CENTER	2	ENNINGTON	V	T	1	9	7	8

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

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

A. Appointments

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

School	City	State	Nature of Appointment	From (year)	To (year)
UNIV. OF VERMONT	BURLINGTH	V T	ASSOCIATE PROFESTOR	1940	Present
					r)

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

B. <u>Teaching</u>

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

School/Institution	City	State	Nature of Teaching	From (year)	To (year)
				1	
			. :		
		A CONTRACTOR OF THE PROPERTY O			

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

vithin the past 10 years. Title	Publication	Year
Title		
,		
TC	e an additional sheet and check this box:	
		;
ivities [See 26 VSA § 1368(a)((14)] Note: Answering #37 is optional. By answ	vering, you are
iting permission to have this info	ormation posted on the web.	
-	arding your professional or community service a	ictivities and
awards.	A A A A A	•
	Activities or Awards	<u> </u>
	. 1	
If necessary, please us	se an additional sheet and check this box:	,
•		*.
actice Setting [See 26 VSA §		
What is the location of your pri	imary practice setting?	•
Town or City: BENN	UINGTON	-
State: \IT		•
State: UT		
anslating Services [See 26 VS	A § 1368(a)(16)]	
anslating Services [See 26 VS	services available at your primary practice loca	tion.
ranslating Services [See 26 VS] Please identify any translating Are any translating services av	A § 1368(a)(16)] services available at your primary practice local vailable at your primary practice location?	tion.
anslating Services [See 26 VS Please identify any translating Are any translating services av	services available at your primary practice local vailable at your primary practice location?	tion.
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anslating Services [See 26 VS Please identify any translating Are any translating services av	services available at your primary practice local vailable at your primary practice location?	tion.

36. Publications [See 26 VSA § 1368(a)(13)] Note: Answering #36 is optional. By answering, you

40. Medicai	/New Patients [See 26 VSA § 1368(a)(17)]
A.	Medicaid participation Do you participate in the Medicaid program? X Yes No
В.	New Medicaid Patients Are you currently accepting new Medicaid patients? Yes No
Part V - C	inical Practice Questions
	all of the boxes below that describe your practice as a physician (check all that apply):
	in clinical practice (in direct patient care) in Vermont
	in clinical practice (in direct patient care) outside Vermont
□ Admir	
☑ Teach	
□ Resea	
,	rrently in active practice
	rently participating in residency or fellowship training? Yes No
	No, please skip the rest of this section and go to Part VI. Are you currently participating in residency or fellowship training? If the answer is tes, please skip the rest of this section and go to Part VI. onth and year did you start practice of medicine in Vermont (excluding residency/fellowship)
training)?	
	0 17 17 18
42. For each	location in Vermont where you provide patient care, please answer all of the questions:
	sary, please describe sites beyond the first 4 on an additional sheet and check this box:
A. Tov	n or city (actual location, not mail address):
Site	1: BENNINGTON
Site	2: RUTLAND
Site	3:
Sit	4: \
	Site 1 Site 2 Site 3 Site 4
Ques	on Site i Site 2
providing	r of weeks per year that you spend lirect patient care at this site: is considered to be 48 weeks / year)

Question	Site 1	Site 2	Site 3	Site 4
C. Chose the one description that best fits the practice setting (of each site). (If you provide hospital care to patients who originate from your office or clinic, chose only the setting from which they originate.)				
Community-based practice including associated hospital care (e.g., solo or group office sites, community health center)	\			
Hospital-based practice (e.g., emergency rooms, in-patient services, out-patient services, laboratory, etc.)				
School or college health center		│	ш	
Business or work site	□		🗆	
Extended care/nursing home				
Other: Planned Paventhood		X		·
Please note the specialty, using the code from the enter the average number of hours during which	vou provide di	rect battent care	s, moraumg ur	igiiosis,
treatment and clinical reporting, in a working we care hours of patients originating from this office	eek. Include bo	clude on-call ho	or A care nones	Site 4
treatment and clinical reporting, in a working we care hours of patients originating from this offic	eek. Include bo	clude on-call ho	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1	clude on-call ho	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this offic	Site 1	clude on-call ho	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1	clude on-call ho	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1	Site 2	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 O 6 0 1	Site 2	ours.	
Specialty Code	Site 1 O 6 0 1	Site 2	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 O 6 0 1	Site 2	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 O 6 0 1	Site 2	ours.	
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 Site 1 Site 1	Site 2 O L O 1 Site 2 O L O 1 Site 2 Site 2 Site 2	Site 3 Site 3 Site 3 Site 3	Site 4
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 Site 1 Site 1 Site 1	Site 2 O L O 1 Site 2 O L O 1 Site 2 Site 2 Site 2 Site 2 Site 2	Site 3 Site 3 Site 3 Site 3	Site 4
treatment and clinical reporting, in a working we care hours of patients originating from this offic Specialty Code	Site 1 Site 1 Site 1 Site 1	Site 2 O L O 1 Site 2 Site 2 Site 2 Site 2 Site 2 Site 2	Site 3 Site 3 Site 3 Site 3	Site 4
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 Site 1 Site 1 Site 1	Site 2 O L O 1 Site 2 O L O 1 Site 2 Site 2 Site 2 Site 2 Site 2	Site 3 Site 3 Site 3 Site 3	Site 4
treatment and clinical reporting, in a working we care hours of patients originating from this office. Specialty Code	Site 1 Site 1 Site 1 Site 1	Site 2 D D 1 Site 2 Site 2 Site 2 Site 2 Site 2 Site 2	Site 3 Site 3 Site 3 Site 3	Site 4

Part VI - Signature

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

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

Date: 10/2/02 EM Applicant of Si

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You <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.

01

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

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You <u>must</u> check one of the two statements below regarding taxes:

A 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

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions or payments in lieu of contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You <u>must</u> check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both.)

or

I hereby certify that I am <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.

or

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

Social Security #

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.

Signature of Applicant

Date 10/

Vermont Department of Health - Board of Medical Practice Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

	Year
tatetate_which license was withdraw	wn, denied, revoked, not renewed, or otherwise
ircumstances under which license was withdraw erminated	wii, deffied, fevoked, flot felicited, or earchite
	_
<u> </u>	
oluntarily surrendered or resigned a license	e to practice medicine or any healing art (Question 1
Attach documents	
	Year
State	
Dircumstances	
Disciplinary charges or action (Question 12)	- Attach documents
Name of organization involved	Date
Duration	
Action taken (circle all that apply)	
Action taken (choic an that apply)	
01 Revocation of right or privilege	12 Leave of absence
02 Suspension of right or privilege	13 Withdrawal of an application 14 Termination or non-renewal of contract
03 Censure	15 Medical Records Suspension
04 Written reprimand or admonition	16 Probation
05 Restriction of right or privilege	17 Assurance of Discontinuance
06 Non-renewal of right or privilege	18 Consent Agreement
07 Fine	19 Letter of Agreement
08 Required performance of public service	20 Expulsion from Membership
09 Education/Training/Counseling/Monitoring	21 Reprimand
10 Denial of rights or privilege	22 Other (specify)
11 Resignation	22 Other (specify)
Circumstances	
•	
\	
Denial of examination privileges (Question	13) - Attach documents
	eges denied
Circumstances under which examination privile	ages defiled

esidency Training Program(s)				· · · · · · · · ·	
ocation of Programs	· · · · · · · · · · · · · · · · · · ·			Year	
circumstances	· · · · · · · · · · · · · · · · · · ·		· .		·
				 	
Affecting Health Care Institution Staff Pri					
nstitution involved		·	· · · · · · · · · · · · · · · · · · ·		
ocation		•		Year	
Dircumstances					
					· · · · · · · · · · · · · · · · · · ·
Type of restriction					
Circumstances of restriction					
Circumstances of restriction					
Circumstances of restriction	estions 18 and 2	0) - Attach	documer		
Circumstances of restriction Criminal Investigation - Proceeding (Qu	estions 18 and 2	0) - Attach	documer	nts	
Circumstances of restriction Criminal Investigation - Proceeding (Qu	estions 18 and 2	0) - Attach	documer	nts	
Criminal Investigation - Proceeding (Qu Court	estions 18 and 2	0) - Attach	documer	nts	
Criminal Investigation - Proceeding (Qu Court City and State Charge Description	estions 18 and 2	0) - Attach	documer	nts	

Vermont Department of Health - Board of Medical Practice Form A

Conviction? Yes No	Date
Plea? Yes No	Date
Medical condition, treatment, use of cl	hemical or illegal substances (Questions 21-27)
Treating organization	
Address	Telephone
•	t - field of practice - use of chemical substances
· · · · · · · · · · · · · · · · · · ·	
Dates of illness of dependency	to
Dates of treatment/	to
Name of Rehabilitation/Professional Ass	istance or Monitoring Program
Address	Telephone
	ooard (Question 19) - Attach documents
Name of Licensing Board	Date
Location of Licensing Board	
Circumstances	

SPECIALTY CODES LIST

(primary care specialties in boldface)

					,
0101	Allergy and Immunology	1501	Anatomic & Clinical Pathology	2201	Surgery
0102	Clinical & Laboratory Immunology	1502	Anatomic Pathology	2202	Surgery Of The Hand
0102	Clinical a Laboratory infinitiology	1503	Clinical Pathology	2203	Pediatric Surgery
0204	Anaethaaialagu	1503	- ···· · · · · · · · · · · · · · · ·	2204	Surgical Critical Care
0201	Anesthesiology		Blood Banking/Transfusion Medicine	2204	General Vascular Surgery
0202	Critical Care Medicine	1505	Chemical Pathology	2205	General Vasculai Surgery
0203	Pain Management	1506	Cytopathology		
	· - · · · - · · · · · · · · · · · · · ·	1507	Dermatopathology	2301	Thoracic Surgery
0301	Colon & Rectal Surgery	1508	Forensic Pathology		
	•	1509	Hematology	2401	Urology
0401	Dermatology	1510	immunopathology	` `	
0402	Dermatopathology	1511	Medical Microbiology	4001	Abdominal Surgery
0403	Clinical & Laboratory Dermatology	1512	Neuropathology	4002	Acupuncture
0404	Dermatological Immunology	1513	Pediatric Pathology	4003	Addiction Medicine
				4004	Adult Reconstructive Orthopedics
0501	Emergency Medicine	1601	Pediatrics	4005	Allergy
0502	Medical Toxicology	1602	Adolescent Medicine	4000	, mo.g,
		1603		4006	Cardiovascular Surgery
0503	Pediatric Emergency Medicine		Clinical & Laboratory Immunology		
0504	Sports Medicine	1604	Medical Toxicology	4007	Clinical Pharmacology
		1605	Neonatal-Perinatal Medicine	4008	Diabetes
0601	Family Practice	1606	Pediatric Cardiology		
0602	Geriatric Medicine	1607	Pediatric Critical Care Medicine	4009	Facial Plastic Surgery
0603	Sports Medicine	1608	Pediatric Emergency Medicine		
		1609	Pediatric Endocrinology	4010	General Practice
0701	Internal Medicine	1610	Pediatric Gastroenterology		
0702	Adolescent Medicine	1611	Pediatric Hematology-Oncology	4011	Gynecology
0703	Cardiac Electrophysiology	1612	Pediatric Infectious Disease	4012	Head & Neck Surgery
0704	Cardiovascular Disease	1613	Pediatric Nephrology	4013	Hepatology
0705	Critical Care Medicine	1614	Pediatric Pulmonology	4014	Homeopathic Medicine
0705	Clinical & Lab Immunology	1615	Pediatric Rheumatology	4015	Immunology
				4015	minidiciogy
0707	Endocrinology Diabetes & Metabolism	1616	Pediatric Sports Medicine	4016	Legal Medicine
0708	Gastroenterology	1617	Children with Special Health Needs		
0709	Geriatric Medicine			4017	Musculoskeletal Oncology
. 0710	Hematology	1701	Physical Medicine & Rehabilitation	4018	Neuroradiology
0711	Infectious Disease		•	4019	Nutrition
0712	Medical Oncology	1801	Plastic Surgery	4020	Obstetrics
0713	Nephrology	1802	Hand Surgery		
0714	Pulmonary Disease			4021	Oral & Maxillofacial Surgery
0715	Rheumatology	1901	Preventive Medicine	4022	Orthopedic Surgery Of The Spine
0716	Sports Medicine	1902	Aerospace Medicine	4023	Orthopedic Trauma
0	Oponio inicajomo	1903	Occupational Medicine	4024	Pain Medicine
0801	Medical Genetics	1904	Public Health & General Preventive	4025	Pediatric Allergy
0802	Clinical Biochemical Genetics	1905	Medical Toxicology		,,
0802	Clinical Biochemical/Molecular Genetics	1906	Underseas Medicine	4026	Pediatric Ophthalmology
		1900	Officerseas Medicine	4027	Pediatric Orthopedics
0804	Clinical Cytogenetics	Damak	inte . O Marriago	4028	Pediatric Surgery (Neurology)
0805	Clinical Genetics (Md)	Psych	iatry & Neurology (Board Name - Not A Specialty)	4029	Pediatric Urology
0806	Clinical Molecular Genetics	2001			Psychoanalysis
			Psychiatry	4030	Psychoanalysis
0901	Neurological Surgery	2002	Neurology		B. P. L. A. L. Delbalana
0902	Critical Care Medicine	2003	Neurology With Special Qualifications	4031	Radioisotopic Pathology
1001	Nuclear Medicine		In Child Neurology	4032	Sports Medicine (Orthopedic Surgery)
	•	2004	Addiction Psychiatry	4033	Traumatic Surgery
1101	Obstetrics & Gynecology	2005	Child & Adolescent Psychiatry	4034	Sleep Medicine
1102	Critical Care Medicine	2006	Forensic Psychiatry	,	
1103	Gynecologic Oncology	2007	Geriatric Psychiatry	9001	Rotating Internship (Residency)
1104	Maternal & Fetal Medicine	2008	Clinical Neurophysiology	9999	Other - Please Specify
1105	Reproductive Endocrinology		· · · · · · · · · · · · · · · · · · ·	•	· •
, 105	Reproductive Endocrinology	2101	Radiology		
1201	Onhthalmalagy	2102	Diagnostic Radiology		
1201	Ophthalmology	2103	Radiation Oncology		
4		2103	Radiation Oncology Radiological Physics		
1301	Orthopaedic Surgery				
1302	Hand Surgery	2105	Nuclear Radiology		
		2106	Pediatric Radiology_		
1401	Otolaryngology	2107	Vascular & Interventional Radiology		
1402	Otology/Neurotology				
1403	Pediatric Otolaryngology		•	*	

STATE OF VERMONT BENNINGTON COUNTY, SS

BENNINGTON SUPERIOR COURT CIVIL ACTION DOCKET NO.

RACHEL L. MIDDLESTEADT	
Plaintiff)	•
SOUTHERN VERMONT WOMEN'S MEDICAL) CENTER, DR. GOLD, THE BENNINGTON) FAMILY PRACTICE, P.A. PAUL GRAETHER,) And John Does I-V) Defendants)	COMPLAINT: Negligence Res Ipsa Loquitor Medical Malpractice Punitive Damages

NOW COMES the Plaintiff, Rachel L. Middlesteadt, by and through undersigned counsel and by way of complaint against the Defendants, and each of them, alleges:

- At all times relevant to this cause of action, the Plaintiff, Rachel L.
 Middlesteadt, was a resident of Bennington County in the State of Vermont.
- The Defendant, Southern Vermont Women's Health Center upon information and belief at all times relevant to this cause of action was and still is a Vermont Corporation with a principal place of business at 187 North Main Street in Rutland, Vermont.
- 3. The Defendant, Dr. Gold, is, and was at all times relevant to this lawsuit, a physician duly licenses to practice his profession in the State of Vermont, with offices at 187 North Main Street in Rutland, Vermont, where service of process will be had upon him. Upon information and belief, the Southern Vermont Women's Health Center is the professional corporation of the individual Dr. Gold, and Plaintiff hereby claims against the Defendant Dr. Gold and his corporation.

- 4. Upon information and belief, the Defendant Bennington Family Practice at all times relevant to this cause of action was and still is a Vermont Corporation with a principal place of business at 140 Hospital Drive, Bennington, Vermont.
- 5. At all times relevant to this cause of action, P.A. Paul Graether was the agent, servant and employee of the Defendant, Bennington Family Practice and at all times relevant to this cause of action was acting in the course and scope and service and agency and employment of the Bennington Family Practice.
- 6. The Plaintiff's cause of action against the Bennington Family
 Practice and P.A. Paul Graether arises from (A) their residence in
 Bennington County, State of Vermont; (B) committing negligence
 and medical malpractice and other tortious acts in Bennington
 County, State of Vermont; (C) causing tortious injury in Bennington
 County, State of Vermont; (D) having sufficient minimum contacts
 with the County of Bennington, State of Vermont, so as to confer
 personal jurisdiction over them. The amount in controversy,
 exclusive of interest and costs, exceeds the minimum jurisdictional
 requirements of the Bennington Superior Court.
- The Plaintiff's cause of action against the Southern Vermont
 Women's Health Center and Dr. Gold arises from their (A)
 transacting business in Bennington County, State of Vermont; (B)
 causing tortious injury to a Bennington County resident; and (C)
 having sufficient minimum contacts with the County of Bennington,
 State of Vermont, so as to confer personal jurisdiction over them.
 The amount in controversy, exclusive of interest and costs, exceeds
 the minimum jurisdictional requirements of the Bennington Superior
 Court.

- At all times relevant to this cause of action, Dr. Gold was the agent, servant and employee of the Southern Vermont Women's Health Center, and at all times relevant to this cause of action was acting in the course and scope and employment and agency of the Southern Vermont Women's Health Center.
- 9. At all times relevant to this cause of action, the Plaintiff, Rachel L. Middlesteadt was in the exercise of ordinary care and caution for her own safety and well-being without any contributory negligence on her part.
- On January 17, 1996, the Plaintiff was admitted to the Southern Vermont Women's Health Center where she was diagnosed as being 6.5 weeks pregnant. The Plaintiff underwent an elective procedure known as vacuum aspiration to terminate her pregnancy. During the procedure, a speculum was inserted into the Plaintiff's vagina. Her cervix was exposed and grasped with a tenaculum. A paracervical block was instilled at 3 and 9 o'clock, using a total of 20 ml. of % zylocaine. The Plaintiff's uterus was sounded to 9 cm and her cervix was progressively dilated to 23 mm. A 7 mm cannula was then inserted into her uterine cavity in an attempt to aspirate the products of conception.
- At all times relevant to this cause of action,, a doctor-patient relationship existed between the Plaintiff and the Southern Vermont Women's Health Center, and the Bennington Family Practice, and Defendant P.A. Paul Graether.

The true names and capacity, whether individual, corporate, associate or otherwise of Defendants, Southern Vermont Women's Health Center and John Does I-V, inclusive, are unknown to the Plaintiff; who therefore sues said Defendants by said fictitious names. Plaintiff is informed and believes, and thereon alleges, that each of said Defendants is negligently or otherwise responsible in some manner for the events and happenings herein referred to and negligently or otherwise caused injuries and damages proximately thereby to the Plaintiff as herein alleged.

Plaintiff is uncertain as to the true names and status of the Southern Vermont Women's Heath Center Defendants, or whether said Defendants are corporations, general partnerships, limited partnerships, unincorporated associations, or otherwise. Plaintiff is informed and believes, and therefore alleges that said Defendants are duly licenses to do business, and were and are doing business under and by virtue of the laws ofd the State of Vt. When the true status of said Defendants is ascertained, Plaintiff prays leave of this Court to amend this Complaint accordingly.

12. Plaintiff further states that the Defendant, Dr. Gold, John Does I-V and the Southern Vermont Women's Health Center were professionally negligent and their conduct did fall below the standard of care of ordinary careful, skillful and prudent physicians in the handling of the Plaintiff's procedure. Furthermore, that as a result of Defendant's mishandling of the Plaintiff's first-trimester pregnancy, not all of her fetal tissue was removed, resulting in an incomplete abortion.

- 13. While Plaintiff was a patient at the Southern Vermont Women's Health Center on January 17, 1996, said Women's Health Center, by and through the agents and employees active within the course and scope of their employment, was negligent by failing to diagnose, recognize, test, detect and appropriately treat the procedure and complications incurred by the Plaintiff, Rachel L. Middlesteadt.
- As a direct and proximate result of the Southern Vermont Women's Health Center's negligence, and the medical malpractice of Dr. Gold, John Does I-V and their agents, servants, and employees, the Plaintiff, Rachel L. Middlesteadt suffered an incomplete abortion at approximately nineteen weeks (19), gestation which resulted in permenent and irreprable mental and physical injury, pain and suffering, mental anguish and increased medical expenses.
- 15. The Defendant, Southern Vermont Women's Health Center failed to exercise reasonable and ordinary care, skill and diligence, and departed from the generally accepted and recognized standard of care or skill of the medical community in the care, assistance and treatment of the Plaintiff, and was therefore negligent in performing its duties to Plaintiff in one or more of the following particulars:
 - A) In failing to adopt or implement policies and procedures sufficient to provide for adequate care, assistance and treatment of the Plaintiff,
 - B) In failing to provide appropriate medical care, assistance, and treatment to Plaintiff under the circumstances:
 - C) In failing to provide proper follow-up care to the Plaintiff;
 - D) In failing to remove the fetal tissue during Plaintiff's procedure;

- E) In failing to pursue a further investigation to explain Plaintiff's pathology report, and in failing up with ultra-sound or a repeat pregnancy test.
- Plaintiff may develop, among other things, a serious coagulation defect.
- G) Defendants made an inadequate warning to the Plaintiff concerning the risks and dangers of a missed or incomplete abortion, and failed to provide any or proper follow-up instructions.
- H) was negligent in its care of the Plaintiff.
- 1) failed to properly care for the Plaintiff.
- J) Operated an inadequate, hazardous, unsafe, and below standard health center which created a hazard to the public and to the Plaintiff.
- K) Abandoned the Plaintiff.
- L) Failed to properly monitor the Plaintiff's condition.
- M) Failed to provide adequate abortion service facilities.
- 16. All of the above referenced acts and or omissions by the Southern Vermont Women's Health Center, and its agents, servants, and employees, constituted departures from accepted standards of care.
- 17. The Defendant, Dr. Gold, and John Doe Defendants I-V, were negligent, careless, and reckless in the following acts of commission or omission in that:
 - A) Failed to properly treat the Plaintiff.
 - B) Failed to properly monitor the Plaintiff;

- C) Abandoned the Plaintiff.
- D) Gave inadequate orders and instructions to the Health Center
 Staff regarding the follow up care of the Plaintiff.
- E) Improperly operated on the Plaintiff.
- F) Neglected to care for the Plaintiff in the manner in which he was obligated to do
- G) Failed to advise and to obtain the informed consent of the Plaintiff with respect to the risks and dangers of an incomplete abortion.
- 17. As a direct and proximate result of one or more of the foregoing negligent acts or missions on the part of the Defendants, and each of them, the Plaintiff, Rachel L. Middlesteadt suffered a missed abortion as a result of which she had to undergo a second abortion at approximately twenty (20) weeks. Said second abortion required admission as an impatient on April 12, 1996 at Triangle Women's Health Clinic in Chapel Hill, North Carolina. Plaintiff has sustained serious and permanent bodily injury, necessitating medical, surgical and related care,, and the reasonable expense thereof. Great pain, distress and anxiety have been suffered and always will be suffered by Rachel L. Middlesteadt. She has required hospital and medical care, aid and attention and may require the same in the future. The emotional pain which is permanent in nature and will cause her lifelog pain, humiliation, suffering, anxiety and embarrassment. The Plaintiff had to undergo another surgical procedure which was far more complex and complicated which was a direct and proximate result of the Defendants and each of them. There is a probability that she will have further complications in the future.

- 18. Plaintiff at all times relevant to this cause of action was free of any contributory negligence.
- 19. Plaintiff requests a jury trial on all issues so triable.

COUNT II

- 20. Plaintiff repeats and realleges paragraphs one through nineteen of the first cause of action of this Complaint, and makes said paragraphs a part of this, the second cause of action, as though fully set firth herein.
- 21. That the Bennington Family Practice holds itself out, portends and otherwise informs the public, and more particularly in the instance of the Plaintiff that it had and possessed the requisite skill, competence, know-how, facilities, personnel, equipment, technology, and information to properly care and treat the Plaintiff.
- 22. That on or about , the Plaintiff, Rachel L. Middlesteadt entered Defendant's Family Practice at 140 Hospital Dive in Bennington, Vermont and entrusted herself entirely to the care of the Defendants and P.A. Paul Graether, and each of them, that the Plaintiff possessed no medical or professional knowledge nor did she have any facilities to care, diagnose, mend or cure herself.
- 23. That at all times mentioned herein, the Plaintiff, Rachel L.
 Middlesteadt, was in the exercise of ordinary care and caution for her own safety and was free of any contributory negligence.
- At all times relevant to this cause of action, a patient-physician relationship existed between Rachel L. Middlesteadt and the Bennington Family Practice and its agents, servants, employees and P.A. Paul Graether.

- 25. That it was incumbent of the Defendant, Bennington Family Practice, and its agents, servants, and employees and P.A. Paul Graether who was and were a fiduciary by virtue of the above, to take appropriate precautions for its patient to wit: the highest degree of care commensurate with its facilities, knowledge, information, technology, and that the Defendants, and each of them, failed to do so.
- That the Defendant, Bennington Family Practice, and its agents, servants, and employees, and in particular P.A. Paul Graether, after assuming the care and treatment of the Plaintiff, Rachel L. Middlesteadt L. Middlesteadt, then and there carelessly and negligently committed one or more of the following acts or omissions of corporate negligence and medical malpractice Interrogatory he treating the Plaintiff herein, as follows:
 - A) Negligently, carelessly and/or improperly failed to render, aid, and service and follow-up care required of a family medical practice through its agents, servants, or employees to the Plaintiff, Rachel L. Middlesteadt;
 - B) Negligently, carelessly and improperly failed to take any to the proper tests or diagnostic procedures to check on the Plaintiff's condition;
 - c) negligently, carelessly and improperly performed or failed to perform a proper pelvic examination of the Plaintiff;
 - Negligently, carelessly and improperly reviewed the Plaintiff's pathology, laboratory and microscopic examination report;
 - E) Negligently, carelessly and improperly failed to utilize ultrasound and sonogram as a very reliable method for diagnosing the Plaintiff's incomplete abortion;

- F) Negligently, carelessly, and improperly failed to utilize a repeat pregnancy test or performing an ultrasound of the Plaintiff's pelvis and uterus to determine its contents:
- On tilize and equip adequate facilities, instruments, technology, and equipment taking into consideration the community wherein the Defendant's Family Practice is located and the degree of medical aid and service that a family medical practice in the Bennington area would ordinarily render;
- H) Negligently, carelessly and improperly failed to do all the necessary post-operative treatment necessary for the care and safety of the Plaintiff;
- Negligently, carelessly and improperly failed to treat the Plaintiff for the post-operative complications for which she suffered;
- J) Negligently, carelessly and improperly failed to provide competent physicians, and consultants necessary for the care, well-being and safety of the Plaintiff;
- K) Negligently entrusted the care and treatment of the Plaintiff, Rachel L. Middlesteadt to PA Pal Graether who carelessly and negligently treated the Plaintiff and who failed to order any diagnostic tests to confirm the Plaintiff's condition;
- L) The Bennington Family Practice carelessly and negligently employed and engaged incompetent and unskilled personnel including P.A. Paul Graether considering the nature of the medical services that the Defendants were rendering on behalf of the Plaintiff;

- M) The Bennington Family Practice carelessly, negligently, improperly and unskillfully attended and treated the Plaintiff, Rachel L. Middlesteadt.
- That as a direct and proximate result of one or more of the foregoing 27. wrongful acts and omissions of the Defendant, Bennington Family Practice, and P.A. Paul Graether, and their agents, servants and employees, the Plaintiff, Rachel L. Middlesteadt, was improperly diagnosed and ill advised and was not told that she suffered an incomplete abortion and as a result, her pregnancy continued for an additional thirteen weeks and although her abortion was incomplete. the Defendants and especially P.A. Paul Graether, did not utilize and I or recommend ultrasound or any test whatsoever to determine whether the Plaintiff was still pregnant. As a result of the above stated negligence, the Plaintiff, Rachel L. Middlesteadt was admitted to a Triangle Women's Health Clinic where she was diagnoses as 19 weeks pregnant and had to undergo a Lamicel / Laminaria cervical dilator procedure in her cervix to terminate her pregnancy. Prior to the procedure, Plaintiff's doctor advised Plaintiff that she should have the procedure because her fetus may have been damaged during the first incomplete abortion. Therefore as a direct and proximate result of the said negligence and carelessness of the Defendants, and each of them, Plaintiff was cause to and did suffer severe and excruciating pain and distressing mental anguish as a result of having to go through an abortion at the nineteenth week of pregnancy. Plaintiff has suffered and for a long period of time to come will continue to suffer said pain and mental anguish as a result of said injuries.

- As a result of the aforesaid injuries, Plaintiff has been generally damaged in a sum in excess of the jurisdictional limits of the Bennington Superior Court.
- 29. In the treatment of the aforesaid injuries, Plaintiff has incurred, and may in the future incur liability for physicians, surgeons, nurses. hospital care, medicine, x-rays, and other medical treatment the true and exact amount thereof being unknown to Plaintiff at this time, and Plaintiff prays leave to amend this Complaint accordingly when the true and exact cost thereof is ascertained by Plaintiff.
- 30. As a direct and proximate result of the said negligence and carelessness of the Defendants and each of them, Plaintiff has incurred and will incur, loss if income, wages, profits and commissions, a diminution if earning potential, and other pecuniary losses, the full nature and extent of which are not yet known to Plaintiff; and leave is requested to amend this Complaint to conform to proof at time of trial.
- Plaintiff requests a jury trial on all issues so triable against the Bennington Family Practice and P.A. Paul Graether.

COUNT III

RES IPSA LOQUITOR

Plaintiff hereby repeats and incorporated by reference paragraphs one through thirty one of the first and second causes of action of this Complaint, and makes said paragraphs a part of this, the third cause of action, as through fully set forth herein.

- During and as a direct and proximate result of the actions and omissions of Dr. Gold and the Southern Vermont Women's Health Center and John Does I-V, along with their agents, servants and employees during the procedure performed on the Plaintiff on or about January 17, 1996, the Plaintiff suffered an incomplete abortion at approximately six and one half weeks gestation. The negligence of the Defendants resulted in the Plaintiff having to undergo a second procedure at which time she was approximately nineteen weeks pregnant.
- During the procedure at the Southern Vermont Women's Health 34. Center, the Plaintiff, Rachel L. Middlesteadt entrusted Plaintiff completely to the care of the Defendants and each of them, and their agents, servants, and employees, and the damage and injury which she received was caused by the procedures, instruments, equipment, treatment and methods, which were and had been completely and exclusively under the Defendants direction, management and control, and in the normal course of events, the injuries and incomplete abortion would not have occurred if the Defendants, and each of them had used ordinary care while performing the procedure and utilizing the instruments and methods under their exclusive control and management. Wherefore, the Plaintiff hereby relies on the inference of negligence arising from the circumstances and general situation allowed under the doctrine of res ipsa loquitor.
- 35. As a proximate result of the negligence of the Defendants, and each of them, under the inference of res ipsa loquitor, Plaintiff sustained the injuries and damages hereinafter set forth.

COUNT FOUR

PUNITIVE DAMAGES

- 36. Plaintiff hereby incorporates and repeats by reference paragraphs one through thirty five of the first, second and third causes of action of this Complaint, and makes said paragraphs a part of this, the fourth cause of action, as though fully set forth herein.
- At all times herein mentioned, the Defendants, Bennington Family Practice, PA Paul Graether, as hereinafter set forth in failing to order any diagnostic tests or to properly refer the Plaintiff to a competent physician in light of her having undergone such a medical procedure to determine whether she had a complete or incomplete abortion constituted recklessness and gross negligence, and a conscious disregard for the safety of the Plaintiff. Plaintiff is therefore entitled to exemplary or punitive damages, which would serve to punish and make examples of these Defendants, and each of them, in an amount to be determined at trial.
- Plaintiff requests a jury trial on all issues so triable in this fourth cause of action.

WHEREFORE, Plaintiff prays judgment against the Defendants, and each of them, as follows:

- For general damages according to proof;
- 2) For exemplary or punitive damages according to proof;
- 3) For Plaintiff's loss of income, wages and earning potential according to proof;
- For Plaintiff's medical and related damages according to proof;
- 5) For Plaintiff's costs of suit herein; and

6) For such other and further relief as to the Court that may seem just and proper.

Dated at Bennington, Vermont this _____ day of December, 1997.

Gerard J. Altieri, Esq. Attorney for the Plaintiff 407 Main Street Bennington, Vermont 05201 (802) 447-3110

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Bennington Family Practice 140 Hospital Drive, Suite 108 Bennington, Vermont 05201

Vermont Department of Health Board of Medical Practices 108 cherry Street PO Box 70 **Burlington, Vermont 05402**

Dear Medical Practice Board,

On my application to renew my license I incorrectly filled out section 29 A. There was no court judgment against me. The section that should have been filled out was 29 B. I have enclosed pages 7 and 8 to replace the original ones I had sent in. Please call if there is any additional information you need to process my license renewal. Thank you for your help in this matter.

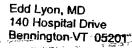
Sincerely,

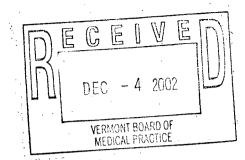
Edd Lyon Mo Edd Lyon, MD



Vermont Department of HealthBoard of Medical Practice

Agency of Human Services





November 25, 2002

Dear Physician:

Your 2002 Physician License Renewal application has been received by this office and cannot be processed until the following information is received.

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\$350 renewal fee	29A was filled out and it was
\$25 late fee	2111 1000 10100 0001 011
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Child Support, Taxes, Unemployment	Compensation Statement
☐ Number 1 – check one of the two s	statements
☐ Number 2 – check one of the two s	statements
☐ Number 3 – check one of the three	e statements
Completed Form A	

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

Thank you.

Sincerely,

Medical Practice Board (802) 657-4220

Enclosures

108 Cherry Street • PO Box 70 • Burlington, VT 05402-0070

TEL 802- 657-4220 or 800-745-7371

FAX 802-657-4227

B. Other Restrictions

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

Da M	te M	D	D	Y	Y	Y	Y	Hospital	State	Name of Action	Action	Reason for Action
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											☐ In Settlement	

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

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

A. Judgments

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

Da M		al	D	Y	Y	Y	Y	Court	:	:	State	Nature of Case	Amount Assessed Against You
		-	<u> </u>	- -	Ī	 	Τ-		<u> </u>	- 1 14 - 1 14 - 1 1		☐ Judgment	
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1-:114			-					-	•			□ Judgment	
		(4r).				4 (1) (1)	- Jan 1		:			☐ Arbitration	
		T	T									☐ Judgment	
	7				- 1				•			☐ Arbitration	

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

B. Settlements



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

Da M		D	D	Y	Y	Y	Y	Court	Sta		Amount of Settlement Against You
0	9	2	1	2	0	0	0	Bennington Superior	V	1	\$ 11,00000
								Court.			

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

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

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

School	City		Sta	ite	Ye. Gra			1
Universidad Autonoma De Buad.	Cundalaja	VA Mixico						
Albany Medical College	A14-1-1		N	4	1	9	7	5
			-					

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

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

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

School/Institution	Specialty		City	Sta		Yea Gra			
UNIV OF DICIA.	FAMILY	PPAITHE	TULS 4	$\boldsymbol{\nu}$	ĸ	1	9	7	p
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If necessary, please use an additional sheet and check this box:

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

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		Ò¶ ves □ no	Am. Bound of F.P.	1978	1997
		□ ves □ no			
		ves 🗆 no)	·	

Edd Lyon, MD 140 Hospital Drive Bennington VT 05201



Vermont Department of HealthBoard of Medical Practice

Agency of Human Services

November 25, 2002

Dear Physician:

Your 2002 Physician License Renewal application has been received by this office and cannot be processed until the following information is received.

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u	25 late fee
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	Page 6, item
3	Page 7, item documentation for 29
	Page 8, item
	Page 9, item
	Page 10, item
	Page 11, item
	Page 12, item
	Page 13, item
	Child Support, Taxes, Unemployment Compensation Statement
	Number 1 – check one of the two statements
	Number 2 – check one of the two statements
	Number 3 – check one of the three statements
	Completed Form A

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

Thank you.

Sincerely,

Medical Practice Board (802) 657-4220

Enclosures

108 Cherry Street • PO Box 70 • Burlington, VT 05402-0070

TEL 802- 657-4220 or 800-745-7371 FAX 802- 657-4227

Edd Lyon, MD 140 Hospital Drive Bennington VT 05201



Vermont Department of Health Board of Medical Practice

Agency of Human Services

November 25, 2002

Dear Physician:

Your 2002 Physician License Renewal application has been received by this office and cannot be processed until the following information is received.

\$350 renewal fee \$25 late fee Page 1, item Page 2, item Page 3, item
Page 4, itemPage 5, item
Page 6, item
Page 7, item documentation for 29
Page 8, item
Page 9, item
Page 10, item
Page 11, item
Page 12, item
Page 13, item
Child Support, Taxes, Unemployment Compensation Statement
☐ Number 1 – check one of the two statements
☐ Number 2 – check one of the two statements
☐ Number 3 – check one of the three statements
Completed Form A

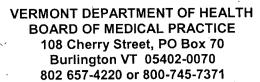
The page(s) that needs completion (if applicable) is attached. Please complete the necessary item, initial, date and return as soon as possible so that processing may be finalized.

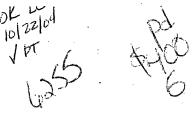
Thank you.

Sincerely,

Medical Practice Board (802) 657-4220

Enclosures





2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

ast Name	First Name	ļ	Middle Name		Suffix		
	•				••		te.
a. Have you ever lega	ally changed your na	ıme?Y	es 🗶 No	in A constraint of the constra			
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n the past two years;				GEP 1	3 7 3		6
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NOTE: The ma	iling address will b	e publicly	listed on the Bo	ard's web sit	e.	•	
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Vermont Department of Health, Board of Medical Practice Physician's License Renewal Application 5-17-04 Page 1 of 15

7. Work Telepl	hone Number with Ar	ea Code: (<u></u> १ १२)	447-1	19)	•
8. E-mail addre	ess:				
Please check	here if the Departmen	t or Health may use t भूरे yes	nis e-maii address	s to send you public health	n'information.
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O More veu	in active practice in \			/es □ no	•
10. Do you ho	old, or have you ever lethe section below an	held, a medical lice	nse in any other	state? ∤oves □ no	
None reported					
State	License Number	Type of License	Date Issued	Status (Active or Ina	active)
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ANY "YES"	RESPONSE TO THE		W MUST BE FUL RM A.	LY EXPLAINED ON THE	ENCLOSED
-	ever applied for and	been denied a licer	nse to practice m	edicine or any other he	aling art?
12. Have you	ever withdrawn an ap	pplication for a licer	nse to practice m	edicine or any other he	aling art?
□ yes	7 no				
	ever voluntarily susp art in lieu of discipli		d or resigned a li	cense to practice medic	ine or any
□ yes	≱ .no				•
by any gover	ormal disciplinary ch nmental authority, by international, nationa	any hospital or he	s any disciplina alth care facility,	ry action ever been take or by any professional	n against you medical
□ yes	≱ no		N.	•	
15. Have you board?	ever been denied the	e privilege of taking	an examination	before any state medica	al examining
⁻ □ yes	½ (no		•		
	ever discontinued ye other than a family ne		ing, or practice f	or a period of more thar	three month
□ yes	y ûno	,		•	i
17. Have you before comp		d or suspended fror	n, or åsked to lea	ave a residency training	program
□ yes	s s (no				
institution de	ever had staff privile enied, reduced, suspe action was initiated a	ended or revoked, o	r appointment ir r resigned from	a hospital or other hea a medical staff after a co	Ith care omplaint or
□ ves	s v ≰(no		•		

Vermont Department of Health, Board of Medical Practice Physician's License Renewal Application 5-17-04 Page 2 of 15 19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes 🙀 no

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

□ yes 🦼 no

PART III

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

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

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

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

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

"Ability to practice medicine" - This term includes:

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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

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

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

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.

gaged in the illegal use of controlled substances? 25. A

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

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

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

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

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. Please provide complete copies of documentation for each matter. None reported

(Conviction Date)

(Court)

(City/State)

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

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

None reported

	iction Date)	(Court)		(City/State)		(Charge)	•
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Medical Malpractice Court Judgments/Settlements [26 VSA § 1368(a)(6A)]

31.

34.	Specialty Board C	ertification [26]	VSA § 1	1368(a)(9)1

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

Family Practice American Board of Family Practice 1978, 1997

Specialty	Specialty Name (if code	Board Certified			Year	Year
Code	unknown)		Name of Board		Certified	Recertified
0601	-	yes □ no	Am. Board M	F.P.	1978	2003
		□ yes □ no		7		

				□ yes	□ no	<u> </u>					<u> </u>
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42.	Medic	caid/New Patients [26 VSA § 1368(a)(17)]	
	Α.	Medicaid participation	· · · · · · · · · · · · · · · · · · ·
× .		Do you participate in the Medicaid program? ★yes □ no	□ not applicable
	В.	New Medicaid Patients	
,		Are you currently accepting new Medicaid patients? Xyes	□ no □ not applicable
		Part V	
		n that the information provided above is true and accurate, and t y knowledge and ability.	hat I have answered the questions to
Date:_		Applicant's Signature	on MD
		Applicant's Signature/	

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

Vermont Department of Health - Board of Medical Practice Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

tate	Year
tate ircumstances under which license was withdrawn	, denied, revoked, not renewed, or otherwise
erminated	
•	
Question 13) Voluntarily surrendered or resign ocuments	ed a license to practice medicine or any healing art
•	
tate	Year
ircumstances	
Question 14) Disciplinary charges or action - A	
lame of organization involved	Date
Ouration	
Action taken (circle all that apply)	
action taken (circle all that apply)	
01 Revocation of right or privilege	12 Leave of absence
02 Suspension of right or privilege 03 Censure	13 Withdrawal of an application 14 Termination or non-renewal of contract
04 Written reprimand or admonition	15 Medical Records Suspension
05 Restriction of right or privilege	16 Probation
06 Non-renewal of right or privilege 07 Fine	17 Assurance of Discontinuance 18 Consent Agreement
08 Required performance of public service	19 Letter of Agreement
09 Education/Training/Counseling/Monitoring	20 Expulsion from Membership
10 Denial of rights or privilege	21 Reprimand
11 Resignation	22 Other (specify)
Dircumstances	
	•
	· ·
•	
- · · · · · · · · · · · · · · · · · · ·	
Overting 45) Deniel of everyingting privileges	Attach decuments
Question 15) Denial of examination privileges	- Attach documents
State	Year
•	
Dircumstances under which examination privilege	s denied
	,

Questions 16 and 17) Residency Training Progoractice - Attach documents	ıram(s) not	complete	d - disco	ntinued e	educa	tion, training
Residency Training Program(s)						<u></u>
Location of Programs			•			
Circumstances						
(Question 18) Affecting Health Care Institution documents						
Institution involved						
Location						
Circumstances						
				. (-
(Question 19) Privilege to prescribe controlled						
Name of organization involved					`	
Type of restriction				j.		
Circumstances of restriction	,	,		ć .		
	1					
1		ζ.				
	· · · · · · · · · · · · · · · · · · ·		. 1			
(Questions 20 and 22) Criminal Investigation -					.	
Court		, ,		,		•
City and State		,				
Charge		,		· ·		
Description				,	,	-
		,				- . •
Clabor						
Status						-
	,					

	Pate	
(Question 21) Investigation by any other licens	ing board - Attach documents	
Name of Licensing Board	Date	
Location of Licensing Board		-
Circumstances		
(Questions 23-25) Medical condition, treatment		
Treating organization		_
Address	Telephone	<u>-</u>
Type of diagnosis, condition or treatment - field of	practice - use of chemical substances	٠
· · · · · · · · · · · · · · · · · · ·		-
Dates of illness or dependency	to	-
Dates of treatment to _		÷.
Name of Rehabilitation/Professional Assistance of		
Address	Telephone	_
Contact person at Program	· ·	
(Question 31) Medical Malpractice Claim		
Please provide the following information regarding photo copied and filled out separately for each cla	g each instance of alleged malpractice. This s	section shou
· · · · · · · · · · · · · · · · · · ·	inn. Maditional officolo may be obtained accu	ii necessary
Insurer		ii necessary
		ii necessary
Insurer		· . — ·
InsurerClaimant name	nis does not constitute an admission of fault on nt;	· · · · · · · · · · · · · · · · · · ·
Claimant name Description of alleged claim (allegations only): The Please indicate: 1. Patient's condition at point of your involvement 2. Patient's condition at end of treatment; 3. The nature and extent of your involvement with 4. Your degree of responsibility for the course of the same o	nis does not constitute an admission of fault on nt;	· . — ·
Claimant name	nis does not constitute an admission of fault on nt;	· . — ·
Claimant name	nis does not constitute an admission of fault on nt;	· . — ·

be

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

Your role (circle one):				
01 Anesthesiologist 02 Primary Care Physician 03 Referring Physician 04 Attending Physician 05 Consultant Specialist 06 Surgeon 07 Fellow 08 PGY 1 09 PGY 2 10 PGY 3	11 PGY 4 12 PGY 5 13 PGY 6 14 PGY 7 15 Workmen's Compensation 16 Court Psychiatrist 17 On-Call Physician 18 Group Practitioner/Partner 19 Other: Specify 20 Unknown			
Your Legal Representative in this matter (includ	·	one number)		¥
Name				
Address	· · · · · · · · · · · · · · · · · · ·			
City, State, Zip Phone				
Indicate Decision, Appeal, Settlement, Dism If a Court or Arbitration Panel heard your case, Court	indicate the following:			
Court's location				,
Docket number	·			
Date the action was filed		· · · · · · · · · · · · · · · · · · ·	· ·	
Decision determined by (check one):	ludge Jury	_Arbitration Pa	nel	
Decision:	Award:	•		
If your case was appealed, indicate the followin Date appeal decided: (month, day, year)	ng: Date appeal filed (month	, day, year)		
If your case was settled, indicate the following:				
Settlement amount paid on your behalf:				
Total settlement amount:		,		·
Date of settlement: (month, day, year)/		•		
Case dismissed against you Aga	ainst all defendants			

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

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

	UNEMPLOYMENT COMPENSATION CONTRIBUTIONS
	You must answer questions 1, 2, and 3.
	Regarding Child Support Title 15 \$ 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed
	unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795) 1. You must check one of the two statements below regarding child support regardless whether or not you have
	children:
	I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order. or
	☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship". Regarding Taxes
•	Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
	2. You must check one of the two statements below regarding taxes: I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	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
	Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lie of contributions due and payable would impose an unreasonable hardship.
	You must check one of the three statements below regarding unemployment contributions or payments in lieu of
	unemployment contributions: I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full complian 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 find 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.

unemployment contributions:

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both.)

I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment

GENERAL RELEASE

TO ALL TO WHOM THESE PRESENTS SHALL COME OR MAY CONCERN, GREETING:

KNOW YE THAT I, Rachel L. Middlesteadt, for and in consideration of the total sum of ELEVEN THOUSAND and NO/100 DOLLARS (\$11,000.00), lawful money of the United States, to me in hand paid by Bennington Family Practice and Clarence Paul Graether, F.N.P., P.A.-C., the receipt whereof is hereby acknowledged, have remised, released and forever discharged and by these presents do for myself, my heirs, executors and administrators and assigns the said Bennington Family Practice and its successors, employees and agents and Clarence Paul Graether, F.N.P., P.A.-C. and his heirs, executors and administrators of and from any and all manner of action and actions, cause and causes of action, suits, damages, judgments, executions, claims for personal injuries, property damage and demands whatsoever, known or unknown, in law or in equity, which I ever had, now have or which my heirs, executors, administrators or assigns hereafter can, shall, or may have against Bennington Family Practice and its successors, employees and agents and Clarence Paul Graether, F.N.P., P.A.-C. and his heirs, executors and administrators for, upon, or by reason of, any matter, cause or thing whatsoever, from the beginning of the world to the day of the date of these presents and particularly, but without in any manner limiting the foregoing, on account of any and all claims arising out of care and treatment provided by agents or employees of Bennington Family Practice, including but not limited to Clarence Paul Graether, F.N.P., P.A.-C., which were or could have been the subject matter of a lawsuit entitled Rachel L. Middlesteadt v. Southern Vermont Women's Health Center, Inc., Bennington Family Practice and Clarence Paul Graether, F.N.P., P.A.-C., filed in Bennington Superior Court, Docket No.: 46-2-98 Bncv.

Settlement Not An Admission of Liability: I, Rachel L. Middlesteadt, further agree that I have accepted payment of the sum specified herein as a complete compromise of matters involving disputed issues of law and fact and I assume the risk that the facts or law may be otherwise than I believe. It is understood and agreed to by the parties that this settlement is a compromise of a doubtful and disputed claim and the payment is not to be construed as an admission of liability on the part of Bennington Family Practice, or any of its employees or agents, including but not limited to Clarence Paul Graether, F.N.P., P.A.-C., by whom liability is expressly denied.

<u>Indemnification</u>: I, Rachel L. Middlesteadt, further promise and bind myselfjointly and severally, to indemnify and hold harmless the said Bennington Family Practice and its successors, employees and agents and Clarence Paul Graether, F.N.P., P.A.-C. and his heirs, executors and administrators, from any lien(s) that may hereafter be asserted with respect to the aforesaid consideration of \$11,000.

<u>Confidentiality</u>: The parties agree that they shall keep the terms and amount of this settlement confidential. Neither party will discuss the amount or terms of this release and agreement with the media or other persons who have no legitimate interest in its terms. Nothing in this paragraph will prohibit either party from discussing the fact of or the terms of this settlement with a spouse, an employee, an attorney, an insurer or any other person or entity with legitimate and lawful reasons for requiring this information.

IT IS FURTHER AGREED that there are no collateral or outside agreements of any kind between the parties hereto and that said payment is an accord and satisfaction of a disputed claim.

I hereby declare and represent that the injuries sustained by me may be permanent and progressive, that all injuries, damages and losses, may not be fully known, and may be more numerous or serious than now expected. In making this release, I rely wholly upon my own judgment about the future development, progress and result of any injuries, known and unknown. I have not been influenced to any extent whatsoever in making this release by any representations (regarding any alleged injuries or the legal liability therefor) made by the releasee, by any person representing the releasee, or by any employee or agent of the releasee. I accept the above-mentioned sum in full settlement of all claims for injuries known or unknown.

IN WITNESS WHEREOF, we have hereunto set our hands and seal this ??

day of

two thousand.
Spelel Middlesteauet
Rachel L. Middlesteadt
COUNTY OF, SS. On thisday of, 2000, before me personally appeared Rachel L.
Middlesteadt, to me known to be the person described herein, and who executed the foregoing release,
and she acknowledged that she executed the same. Before me,
Notary Public

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



2006 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Numb	er: 042-0006255			
Your legal name:		V .		
Edd Gilbert Lyon				
a. Have you ever legal	lly changed your name?	Yes <u>X</u> No		
If yes, enter your form	er name and any other	name(s) under which you	i were licensed in V	ermont or elsev
n the past two years;				
_ast Name	First Name	Middle Name:	Suffi	x .
n Indicate vour name	, as it should appear on	your license	· · · · · · · · · · · · · · · · · · ·	d.
•		Gilbert	M D	
Lyon ast Name	Edd First Name	Middle Name:	Suffi:	×
			TEREIT	TEIN
our Date of Birth:				
Home Address and e	email address:		CEP 28	2006
140 Hospital Dr.,		·		·
Bennington, VT (05201		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3/01/0E
ork Address:	· .		سد دانستان المساور الم	
140 Hospital Dr.,	Sto. 108		· · · · · · · · · · · · · · · · · · ·	•
Bennington, VT			•	
	*.			
ease check your pre NOTE: The mail	eferred mailing addres ing address will be pu	ss: Home X blicly listed on the Boa		
. •				
ome Telephone Num	nber with Area Code:			· ·
ork Telephone Num	ber with Area Code: (802) 447-1191	· ·	
-mail address (if not	appearing in #3):	,		

Vermont Department of Health, Board of Medical Practice Physician 2006 Renewal License Application (Revised 6/14/96) Page 1 of 378

		PAI	RT II	ı	
9. Were you	in active practice in Ve	rmont in the past	12 Months?	xp yes □ no	
10. Do you ho ∑ yes		eld, a medical lice	nse (includin	g temporary) in any other sta	te?
If yes, comple	te the section below and	attach additional p	ages if necess	ary.	
State	License Number	Type of License	Date Issued	Status (Active, Inactive, or oth e.g. conditioned, restricted, lin	
/ OK 19	975	Medical		inactive	
		•			
ANY "YES"	' RESPONSE TO THE Q		W MUST BE F RM A.	ULLY EXPLAINED ON THE E	NCLOSED
-	u ever applied for and b	een denied a lice	nse to practic	e medicine or any other heali	ng art?
12. Have you	ı ever withdrawn an app	lication for a lice	nse to practic	e medicine or any other heali	ng art?
. u yes	X no			3 · · · · · · · · · · · · · · · · · · ·	•
	ı ever voluntarily suspe g art in lieu of disciplina		d or resigned	a license to practice medicin	e or any
□ yes	s Xino				
by any gove		iny hospital or he		inary action ever been taken ity, or by any professional m	
□ yes	s <u>x</u> no	•			
15. Have you board?	ı ever been denied the p	orivilege of taking	an examinati	on before any state medical (examining
□ yes	s Xano				
	ı ever discontinued you other than a family need		ing, or praction	e for a period of more than t	hree month
□ yes	s Xi no	;	•		
17. Have you before comp		or suspended from	n, or asked to	leave a residency training pr	ogram
□ yes	s <u>x</u> p no				
institution d		ded or revoked, o		t in a hospital or other health m a medical staff after a com	
`□ yes	s X⊨no				•
				d substances ever been susp n or federal agency at any tin	

Vermont Department of Health, Board of Medical Practice Physician 2006 Renewal License Application (Revised 6/14/06) Page 2 of 378

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

□ yes □Xno

□ yes □Xno

PART III

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

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

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

None reporte	· ·		
(Conviction Date)	、(Court)	(City/State)	(Crime)
Nolo Contendere/Ma	tters Continued [26	VSA § 1368(a)(2)]	k here if none
Please provide a desc where sufficient facts of	ription of all charges to	to which you pleaded "nolo co d the matter was continued w	rithout a finding by a court
Please provide a desc where sufficient facts of	ription of all charges to	to which you pleaded "nolo co d the matter was continued w ase provide complete copie	rithout a finding by a court
Please provide a desc where sufficient facts of competent jurisdiction	ription of all charges to guilt were found and not listed below. Plea	d the matter was continued w	rithout a finding by a court
Please provide a desc where sufficient facts of competent jurisdiction matter.	ription of all charges to guilt were found and not listed below. Plea	d the matter was continued w	rithout a finding by a court

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)		-	
_	•						
<u>Lice</u>	nsing or Certification	Authority M	atters in Other S	tates [26 VS			
		•			Check he	ere if none	!
states courts	e provide a description , the findings, conclusi , if appealed, in those mentation for each m	ons, and ordestates, if not	ers of such author	ities, and fina	disposition	of such m	
	None reported						
			, * ,				•
(Date	of Final Disposition)(Li	censing or C	ertification Author	ity) (Court)	(City/State)	(Nature o	of Cha
Postr	iction of Hospital Priv	ilogos `[26 \	/SV 8 1388(2)/2)/	·			
Kesu	iction of Hospital Fin	riieges (20)	V3A 9 1300(a)(3)[
A.	Revocation/Involur	ntary Restric	ctions		Check he	ere if none	
	Please provide a de that were related to any other official of to you if not listed be	scription of a competence the hospital a	ny revocation or in or character and v lifter procedural du	were issued b le process (o	striction of your striction of your striction of your strict of your strict of the str	our hospita al's goverr r hearing)	al privil ning bo was a
	Please provide a de that were related to any other official of to you if not listed be	scription of a competence the hospital a elow. Please	ny revocation or in or character and v lifter procedural du	were issued b le process (o	striction of your striction of your striction of your strict of your strict of the str	our hospita al's goverr r hearing)	al privil ning bo was a
	Please provide a de that were related to any other official of the second control of the	scription of a competence the hospital a elow. Please	ny revocation or in or character and v lifter procedural du	were issued b le process (o	striction of your striction of your striction of your strict of your strict of the str	our hospita al's goverr r hearing)	al privil ning bo was a
	Please provide a de that were related to any other official of to you if not listed be	scription of a competence the hospital a elow. Please	ny revocation or ir or character and v ifter procedural du provide complet	were issued b le process (o	striction of your striction of your the hospital portunity for documentat	our hospita al's goverr r hearing)	al privil ning bo was a nch ma
В.	Please provide a de that were related to any other official of to you if not listed be	scription of a competence the hospital aclow. Please ted	ny revocation or ir or character and v ifter procedural du provide complet	were issued be process (on e copies of o	striction of your striction of your the hospital portunity for documentat	our hospita al's govern r hearing) ion for ea	al privil ning bo was a ach ma
	Please provide a de that were related to any other official of to you if not listed be None repor	scription of a competence the hospital a elow. Please ted ospital) scription of a privileges at a petence or clean	ny revocation or in or character and waster procedural du provide complet (State) (Natural resignations from a hospital taken in haracter in that ho	were issued be process (of e copies of e	striction of your the hospital portunity for documentate tion) (Reasonable Check hosettlement of the control of	our hospital's govern r hearing) ion for ea son for Re ere if none dical staff if	al privil ning bo was ar ach ma estriction
	Please provide a de that were related to any other official of to you if not listed be None report (Date) (H Other Restrictions Please provide a de or the restriction of passe related to com	scription of a competence the hospital alelow. Please ted ospital) scription of a privileges at a petence or clf documental	ny revocation or in or character and waster procedural du provide complet (State) (Natural resignations from a hospital taken in haracter in that ho	were issued be process (of e copies of e	striction of your the hospital portunity for documentate tion) (Reasonable Check hosettlement of the control of	our hospital's govern r hearing) ion for ea son for Re ere if none dical staff if	al privil ning bo was a ach ma estriction
	Please provide a de that were related to any other official of to you if not listed be None report (Date) (H Other Restrictions Please provide a de or the restriction of case related to com complete copies of	scription of a competence the hospital alelow. Please ted ospital) scription of a privileges at a petence or clf documental	ny revocation or in or character and waster procedural du provide complet (State) (Natural la l	were issued be process (of e copies of e	striction of your the hospital portunity for documentate tion) (Reasonable Check hosettlement of the control of	our hospital's govern r hearing) ion for ea son for Re ere if none dical staff if	al privil ning bo was at ach ma estriction
	Please provide a de that were related to any other official of to you if not listed be None report (Date) (H Other Restrictions Please provide a de or the restriction of case related to com complete copies of the report	scription of a competence the hospital alelow. Please ted ospital) scription of a privileges at a petence or clf documental	ny revocation or in or character and waster procedural du provide complet (State) (Natural de la hospital taken in haracter in that hospital taken materion for each materiol each each each each each each each each	were issued be process (of e copies of e copies	striction of your the hospital opportunity for documentate tion) (Reason of the control of the c	our hospital's govern r hearing) ion for ea son for Re ere if none dical staff in f, a pendin Please pro	al privil ning bo was a ach ma estriction

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

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

None reported

(Date)	(Court)	∠ (State) (Nature o	f Case) (A	Amount Ass	sessed Agair	ist You)
Settlement	<u>s</u>				□ Check h	ere if none	
past 10 yea party if not	irs (10 years fr listed below. P	rom payment Please provid	ements of med date) in which le complete cof of the compla	a payment opies of do	was awarde cumentati	ed to a comp	laining
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	y involved in			Settled	out o	f court	by MA
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		[26 VSA § 13	68(a)(7)]			nent Against	
(Date) dical Profession ase provide the led below. BANY MEDICA 1975	nal Schools	[26 VSA § 13 lical professio	68(a)(7)]			•	
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34. Specialty Board Certification [26 VSA § 1368(a)(9)]

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

Family Practice American Board of Family Practice 1978, 1997, 2003

32.

33.

Specialty	Specialty Name (if code	Board Certified		Year	Year
Code	unknown)		Name of Board	Certified	Recertified
0601		yes □ no	ABF.P.	1978	2003
		□ yes □ no			
<u> </u>					1

L				
				\$ 1
<u>Year</u>	s of Practice [26 VSA § 1368(a)(10)]			
Mont	h and year you started practicing as a phy	ysician? 8//1978		*
Hos	spital Privileges [26 VSA § 1368(a)(11)]		□ Check her	e if none
List a	all information for all hospitals where you o	currently have hospital s	taff privileges if	not listed below:
	Southwestern Med. Ctr. VT			
	(1978-)			
(Nam	ne) (City)	(State)		(Year Started)
		•		
App	ointments/Teaching [26 VSA § 1368(a)	(12)]		
	: Answering #37 is optional. By answering te web, <u>exactly as provided to the Boar</u>		ission to have th	his information posted
Α.	<u>Appointments</u>		□ Check her	re if none
	Please provide information about your faculties if not listed.	appointments to medica	al school or prof	fessional school
	None reported			•
	None reported			•
	(School) (City) (State)	(Nature of Appoint	ment) F	rom (year) To (year)
В.	Teaching		□ Check hei	re if none
	Please provide information regarding within the past 10 years if not listed.	your responsibility for te	aching graduate	e medical education
	None reported			·
Ilni	iversity of Vt School of Med. B	urlington Vt Cli	inical instri	untor 1008_pres
_0112	(School/Institution) (City)	(State) (Nature of Te		om (year) To (year)
<u> P</u>	ublications: [26 VSA § 1368(a)(13)]		□ Check he	re if none
	e: Answering #38 is optional. By answering the web, <u>exactly as provided to the Boar</u>		nission to have t	his information poster
	se provide information regarding your pub ears if not listed	olications in peer-review	ed medical litera	ature within the past
,			<u>.</u>	
(Title	ے) (Puhl	lication)		(Year)

Vermont Department of Health, Board of Medical Practice Physician 2006 Renewal License Application (Revised 6/14/06) Page 7 of 378

	(Title)	(Publication)	(Year)
٠	(Title)	(Publication)	(Year)
39.	Activities [26 VSA § 1	368(a)(14)]	□ Check here if none
	Note: Answering #39 is op on the web, exactly as pre		g permission to have this information posted
	Please provide information listed.	n regarding your professional or comr	munity service activities and awards if not
	None reported		
	**	(Activities or Awards)	
	· · · · · · · · · · · · · · · · · · ·	(Activities or Awards)	
		(Activities or Awards)	
40.	Practice Setting [26 VSA	\ § 1368(a)(15)]	□ Check here if none
	What is the location of you	r primary practice setting? BEN	NINGTON, VT
41. ,	Translating Services [26	S VSA § 1368(a)(16)]	□ Check here if none
		es available at your primary practice lesses available:	
	If necessar	y, please use an additional sheet and	check this box:□
42.	Medicaid/New Patients	[26 VSA § 1368(a)(17)]	
	A. <u>Medicaid participate</u> Do you participate	pation e in the Medicaid program?	⊈ yes □ no □ not applicable
	B. New Medicaid Pa		www no - not onvitogisto
	Are you currently	accepting new Medicaid patients?	≭yes □ no □ not applicable
		Part V	
	eby affirm that the information pest of my knowledge and abi		e, and that I have answered the questions to
Date	9/17/04	- W	1 Sjon M
	ı t	Applicant's Signatu	re //

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

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

Appointments to medical school or professional school faculties, and an indication you have had a responsibility for teaching graduate medical education within the la	st 10 years
□ Information regarding publications in peer-reviewed medical literature within the last	t 10 years.
□ Information regarding professional or community service activities and awards.	•

Again, thank you for your cooperation.

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

You	must	answer	questions	1	2	and	3
ıou	must	aliswei	uuesuuns	٠.	۷.	anu	J.

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)

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.

I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

You must check one of the two statements below regarding taxes: I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).

I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)

or I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

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.

Date of Birth Social Security # The disclosure or your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

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

Signature of Applicant Date Vermont Department of Health, Board of Physician 2006 Renewal License Applicat Page 15 of 378

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



2008 PHYSICIAN'S LICENSE RENEWAL APPLICATION

			PART I	PERSONAL PROPERTY OF THE PROPE
	License Nu	OCT 2 1 2008		
1.	Your legal name:	Various Great V		
	Edd Gilber	t Lyon		Secretary and the secretary an
	a. Have you ever	legally changed your name?	Yes _X No	
,	If yes, enter your f in the past two year	former name and any other nars;	ame(s) under which you wer	re licensed in Vermont or elsewhere
	Last Name	First Name	Middle Name:	Suffix
	b. Indicate your na	ame, as it should appear on y	our license:	
	Last Name	First Name	Middle Name:	Suffix
2.	Your Date of Birti	h:		
3.	Home Address a	nd email address:		
		ospital Dr., Ste. 108- naton VT 05201		
4.		ospital Dr., Ste. 108 ngton, VT 05201		
5. F		preferred mailing address nailing address will be pub	: Home Work licly listed on the Board's v	veb site.
6. H	iome Telephone N	lumber with Area Code: (_		
7. V	Vork Telephone N	umber with Area Code: (902, 447-1191	
8. E	-mail address (if r	not appearing in #3):		
Plea XV9	ase check here if thes	e Department of Health may	use this e-mail address to so	end you public health information.

PART II

Xyes □ no 1978 20		¥yes □ no)						
If necessary, please use an additional sheet and check this box:		If yes, complete the section below and attach additional pages if necessary.							
If necessary, please use an additional sheet and check this box:□ Medical Professional Schools [26 VSA § 1368(a)(7)] Please provide the names of medical professional schools you attended and the dates of graduation if not listed below. ALBANY MEDICAL COLLEGE, NY 1975 Graduate Medical Education/Residency [26 VSA § 1368(a)(8)] Please provide information about any graduate medical education/residency attended or completed that is not listed below. University of Oklahoma College of Medicine-Tulsa ,OK Family Practice 1978 If necessary, please use an additional sheet and check this box:□ Specialty Board Certification [26 VSA § 1368(a)(9)] Please verify the following information regarding your specialty board certification and update as necessar using the attached Specialty Codes List. Family Practice American Board of Family Practice 1978, 1997, 2003 Specialty Specialty Name (if code Board Certified Name of Board Certified Rece Certified Name of Board Certified Rece Certified Rece		State	License Number		Date Issued	Status (Active, I	nactive, or tricted, lin	other, nited)	
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ALBANY MEDICAL COLLEGE, NY 1975 Graduate Medical Education/Residency [26 VSA § 1368(a)(8)] Please provide information about any graduate medical education/residency attended or completed that is not listed below. University of Oklahoma College of Medicine-Tulsa ,OK Family Practice 1978 If necessary, please use an additional sheet and check this box:□ Specialty Board Certification [26 VSA § 1368(a)(9)] Please verify the following information regarding your specialty board certification and update as necessar using the attached Specialty Codes List. Family Practice American Board of Family Practice 1978, 1997, 2003 Specialty Specialty Name (if code unknown)		Medical Pro	ofessional Schools [26 VS	A § 1368(a)(7)]					
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Code unknown) Name of Board Certified Rece yes □ no 1978 20		American Bo	pard of Family Practice						
77/6 20				Board Certified	Name of Boa			Year Recertifie	
	-			yes □ no			1978	2003	
Li yes Li no	Ĺ	······		□ yes □ no					
Voore of Proofice 196 \/SA S 1969/a\/10\3		rears of Pra	<u>actice</u> [26 VSA § 1368(a)(10	J)]					

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

Vermont Department of Health, Board of Medical Practice Physician 2008 Renewal License Application (Revised 5/28/08) Page 2 of 14

Southwestern	Med.	Ctr.
VT		
(1978-)		

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

- 16. Have you ever applied for and been denied a license to practice medicine or any other healing art?
 □ yes ≰no
- 17. Have you ever withdrawn an application for a license to practice medicine or any other healing art?

□ yes x(no

18. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes 🏋 no

19. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes 🕱 no

20. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□yes atno

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?

□ yes 🗽 no

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□yes koʻno

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes 🕦 no

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

□ yes ⊈no

25. Do you currently or have you ever prescribed any prescription medication over the internet?

□ yes ≰no

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

□ yes **y**≰no

PART III

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

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

- 27. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?
- 28. 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 29 through 31.

"Ability to practice medicine" - This term includes:

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.
- "Currently" This term means recently enough to have a real or perceived impact on one's functioning as a licensee.
- "Chemical substances" This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- "Controlled substances" This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).
- "Illegal use of controlled substances" This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.
- 29. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?
 - In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.
- 30. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

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

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. <u>Criminal Convictions</u> [26 VSA § 1368(a)(1)]

▼ Check here if none

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

None reported

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

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

None reported

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

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

None reported

35. <u>Licensing or Certification Authority Matters in Other States</u> [26 VSA § 1368(a)(4)] **Check here if none

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

None reported

- 36. Restriction of Hospital Privileges [26 VSA § 1368(a)(5)]
 - A. Revocation/Involuntary Restrictions

X Check here if none

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

None reported

B. Other Restrictions

Check here if none

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

None reported

37. <u>Medical Malpractice Court Judgments/Settlements</u> [26 VSA § 1368(a)(6A)]

A. Judgments

Check here if none

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

None reported

B. Settlements

□ Check here if none

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

8/22/2000

Bennington Superior Court VT

11000

Improper treatment: Obstetrics/Gynecology-related; Named as member of practice, not directly involved in patient's care.

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

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

A. Appointments

□ Check here if none

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

University of Vermont Burlington, VT Associate Professor 1990 - present

B. Teaching

□ Check here if none

	None reported	
39. <u>Pu</u>	ublications: [26 VSA § 1368(a)(13)]	Check here if none
No on	ote: Answering #39 is optional. By answering, you are grant the web, exactly as provided to the Board.	anting permission to have this information posted
Ple 10	ease provide information regarding your publications in p years if not listed.	peer-reviewed medical literature within the past
40. <u>Ac</u>	<u>:tivities</u> [26 VSA § 1368(a)(14)]	□ Check here if none
No on	ote: Answering #40 is optional. By answering, you are grathe web, exactly as provided to the Board.	
Ple list	ease provide information regarding your professional or ded.	community service activities and awards if not
	None reported	
41. <u>Pra</u>	actice Setting [26 VSA § 1368(a)(15)]	☐ Check here if none
Wh	nat is the location of your primary practice setting?	
	BENNINGTON, VT	
42. <u>Tra</u>	anslating Services [26 VSA § 1368(a)(16)]	Check here if none
Ple Are	ease identify any translating services available at your pr e any translating services available at your primary pract	imary practice location. ice location?
If y	ves, please describe here the translating services availab	ole:
	None	
43. <u>Me</u>	edicaid/New Patients [26 VSA § 1368(a)(17)]	
A.	Medicaid participation	
	Do you participate in the Medicaid program?) yes □ no
B.	New Medicaid Patients	
	Are you currently accepting new Medicaid patients'	? ⊠yes □ no
	Part V	
Reminder -	- You must also complete the enclosed Applicant's S	Statement Regarding Child Support, Taxes,

Unemployment Compensation Contributions regardless of whether or not you have children

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to

Please provide information regarding your responsibility for teaching graduate medical education

within the past 10 years if not listed.

Vermont Department of Health, Board of Medical Practice Physician 2008 Renewal License Application (Revised 5/28/08) Page 7 of 14

the best of my knowledge and ability.

Date: 9/10/07

Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

Again, thank you for your cooperation.

Appointments to medical school or professional school faculties, and an indication as to whethe you have had a responsibility for teaching graduate medical education within the last 10 years.
Information regarding publications in peer-reviewed medical literature within the last 10 years.
Information regarding professional or community service activities and awards.

Vermont Department of Health, Board of Medical Practice Physician 2008 Renewal License Application (Revised 5/28/08) Page 9 of 14

Vermont Department of Health - Board of Medical Practice Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Attach

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State	Year
State	n, denied, revoked, not renewed, or otherwise
(Question 18) Voluntarily surrendered or resig documents	ned a license to practice medicine or any healing ar
State	Year
Circumstances	
(Question 19) Disciplinary charges or action - A	Attach documents
Name of organization involved	Date
Duration	
Action taken (circle all that apply)	
01 Revocation of right or privilege 02 Suspension of right or privilege 03 Censure 04 Written reprimand or admonition 05 Restriction of right or privilege 06 Non-renewal of right or privilege 07 Fine 08 Required performance of public service 09 Education/Training/Counseling/Monitoring 10 Denial of rights or privilege	12 Leave of absence 13 Withdrawal of an application 14 Termination or non-renewal of contract 15 Medical Records Suspension 16 Probation 17 Assurance of Discontinuance 18 Consent Agreement 19 Letter of Agreement 20 Expulsion from Membership 21 Reprimand 22 Other (specify)
Dircumstances	
Question 20) Denial of examination privileges	- Attach documents
State	Year
Dircumstances under which examination privileges	s denied

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training practice - Attach documents				
Residency Training Program(s)				
Location of Programs				
Circumstances				
(Question 23) Affecting Health Care Institution Staff Pri documents	ivileges, Employment or Appointment - Attach			
Institution involved				
Location				
Circumstances				
(Question 24) Privilege to prescribe controlled substan				
Name of organization involved				
Type of restriction	Date			
Circumstances of restriction				
Question 25) Internet prescribing				
Please provide a general description of your practice of inte	ernet prescribing			

(Questions 26 and 28) Criminal Inve	estigation - Proceeding - Attach documents
Court	
Status	
Conviction? Yes No	Data
Plea? Yes No	Date
	Dateother licensing board - Attach documents
	Date
	, treatment, use of chemical or illegal substances
Treating organization	
	Telephone
Type of diagnosis, condition or treatme	ent - field of practice - use of chemical substances
Dates of illness or dependency	to
Dates of treatment	
Name of Rehabilitation/Professional As	ssistance or Monitoring Program
Address	Telephone
Contact person at Program	· ·

(Question 37) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.				
	y): This does not constitute an admission of fault or liability.			
Please indicate: 1. Patient's condition at point of your involved. 2. Patient's condition at end of treatment; 3. The nature and extent of your involvemed. 4. Your degree of responsibility for the county. 5. Narrative of event.				
	licate cause of death according to autopsy or patient chart:			
Your role (circle one):				
01 Anesthesiologist 02 Primary Care Physician 03 Referring Physician 04 Attending Physician 05 Consultant Specialist 06 Surgeon 07 Fellow 08 PGY 1 09 PGY 2 10 PGY 3	11 PGY 4 12 PGY 5 13 PGY 6 14 PGY 7 15 Workmen's Compensation Evaluator 16 Court Psychiatrist 17 On-Call Physician 18 Group Practitioner/Partner 19 Other: Specify 20 Unknown			
Your Legal Representative in this matter (inc	clude name, address and telephone number)			
Name				
City, State, Zip				
Phone				
indicate Decision, Appeal, Settlement, Dis f a Court or Arbitration Panel heard your cas				
Court	•			

Court's location	
Docket number	
Date the action was filed	
Decision determined by (check one): Judge Jury Arbitration Panel	
Decision: Award:	
If your case was appealed, indicate the following: Date appeal filed (month, day, year)/	/
If your case was settled, indicate the following:	
Settlement amount paid on your behalf:	
Total settlement amount:	
Date of settlement: (month, day, year)//	
Case dismissed against you Against all defendants	
Important: In addition to the above information, please attach a copy of the complaint and settlement and release, or other final disposition of the claim. This information can be oblegal representative.	final judgment, tained from you
Additional information, if any:	
	·

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than pro-thyelith of the application is filed. "Good standing" means that less than pro-thyelith of the application is given by the support payable under a support order as of the date the application is filed. "Good standing" means that less than pro-thyelith of the application is given by the support payable under a support order. n

for any	y supp office	ort payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an e hardship. (15 V.S.A. § 795)
1.	You	I <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.
		I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".
		Regarding Taxes
persor returns	i certifi s have	3 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the es 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 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.	You M	must check one of the two statements below regarding taxes: I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
		I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship". Regarding Unemployment Compensation Contributions
(includ with ar unit is of the o payme contrib approv	ing a ling a ling emp in goodate su nts in linguitions ed by linguitions	8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business icense to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space loying unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing distanding with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as each declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or ieu of contributions payable if: (1) no contributions or payments in lieu of contributions payable; (2) the liability for any or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in autions due and payable would impose an unreasonable hardship.
3. contrib	You	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 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.)
3	a	I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
		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 S		
ne vep	artme	are 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 ADDITIONS

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

Signature of Applicant Date

Vermont Department of Health, Board of Medical Practice Physician 2008 Renewal License Application (Revised 5/28/08) Page 15 of 14

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:

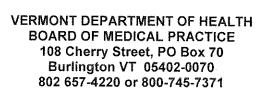
- (1) 60 days or fewer have elapsed since the date a judgment was issued; or
- (2) the person is in compliance with a repayment plan approved by the judiciary.

Edd Han

Date: 9/10/08

PLEASE NOTE:

In accordance with 4 V.S.A. § 1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.





2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PARTI

	License Numb	er: 042-0006255		
1.	Your legal name:			OCT - 1 2010
	Edd Gilbert Lyd	on		UCI ΠΑΝΙ
	a. Have you ever legall	y changed your name?	Yes/ No	Verment Econolo Is edical Fr. edica
	If yes, enter your forme elsewhere in the past to	er name and any other r wo years;	name(s) under which you were	licensed in Vermont or
	Last Name	First Name	Middle Name:	Suffix
	b. Indicate your name,	as it should appear on	your license:	
	Last Name	First Name	Middle Name:	Suffix
2.	Your Date of Birth:			
3.	Mailing Address and	email address:		
4.	Rennington Work Address:	al Dr., Ste. 108		
5. F	Please check your pref NOTE: <i>The mailin</i>		: HomeWork dicly listed on the Board's w	eb site.
6. F	lome Telephone Numb	er with Area Code: (_)	
7. V	Vork Telephone Numb	er with Area Code: ()	
8. E	-mail address (if not a	ppearing in #3):		

Please check here if the Department of Health may use this e-mail address to send you public health information.

[7]	ves	□ no	1
ئبا	V C C	- III III	,

PART II

9.	were you	in active clinical practice	in Vermont in t	he past	12 Months?	X yes □ no				
10.	Do you ho	old, or have you ever held □ no	, a medical licer	nse (inc	luding tempo	rary) in any other	state?			
	If yes, complete the section below and attach additional pages if necessary.									
	State	License Number	Type of L	icense	Date Issued	Status (Active, Inactive, or conditioned, restricted, limit				
		OK 1975								
		If necessary, plea	ase use an additi	onal she	et and check	this box:□				
11.	Medic	al Professional Schools	[26 VSA § 1368(a)(7)]						
	Please	e provide the names of med ation if not listed below.			you attended	and the dates of				
		ALBANY MEDICAL COLL 1975	EGE, NY							
12.	<u>Gradu</u>	ate Medical Education/Re	esidency [26 VS	A § 136	8(a)(8)]					
	Please comple	Please provide information about any graduate medical education/residency attended or completed that is not listed below.								
		University of Oklahoma C Family Practice 1978	ollege of Medicin	e-Tulsa	,OK					
		If necessary, please	use an addition	al sheet	and check this	s box:□				
13.	<u>Speci</u> a	alty Board Certification [2	26 VSA § 1368(a)(9)]						
	Please necess	verify the following informa sary using the attached Spe	ation regarding ye	our spec	cialty board ce	rtification and upda	te as			
	Americ	Practice can Board of Family Practic 1997, 2003	e							
Spe Coc	cialty le	Specialty Name (if code unknown)	Board Certified		of Board	Year Certified	Year			
	0601	diadiowij	Xyes □ no		3FP	(978	Recertified			
			□ yes □ no	,,,,		1 770				
14.		of Practice [26 VSA § 136 and year you started practi		an? A	ug-78					
15.	Hosp	ital Privileges [26 VSA §	1368(a)(11)]			☐ Check here if no	ene			
	List all	information for all hospitals	where you curre	ntly hav	e hospital staf	f nrivileges if not lie	ted			

Vermont Department of Health, Board of Medical Practice Physician 2010 Renewal License Application (Revised 3/10/10) Page 2 of 17

below:

Southwestern Med. Ctr. VT (1978-)

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

16. Have you ever applied for and been denied a license to practice medicine or any other healing art?

□ yes à no

17. Have you ever withdrawn an application for a license to practice medicine or any other healing art?

□ yes bano

18. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes ¬s√no

19. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes ∯×ηα

20. Have you ever been denied the privilege of taking an examination before any state medical examining board?

⊡yes ⊸√ino

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?

□ yes 🙎 no

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

gyes vano

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes [varno

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

□ yes "pi\no

25. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.

□yes b\(no

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

□ yes 🚉 no

PART III

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

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

- 27. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?
- 28. 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 29 through 31.

"Ability to practice medicine" - This term includes:

- 1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
- 3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
- "Medical condition" Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.
- "Currently" This term means recently enough to have a real or perceived impact on one's functioning as a licensee.
- "Chemical substances" This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- "Controlled substances" This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).
- "Illegal use of controlled substances" This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.
- 29. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

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

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

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your

use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. <u>Criminal Convictions</u> [26 VSA § 1368(a)(1)] Check here if none

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

None reported

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

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

None reported

34. <u>Vermont Board of Medical Practice Matters</u> [26 VSA § 1368(a)(3)] © Check here if none

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

None reported

35. <u>Licensing or Certification Authority Matters in Other States</u> [26 VSA § 1368(a)(4)] ©-Check here if none

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

None reported

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

A. Revocation/Involuntary Restrictions

Check here if none

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

None reported

B. Other Restrictions

Check here if none

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

None reported

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

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

None reported

B. Settlements

Check here if none

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

8/22/2000

Bennington Superior Court VT

11000

Improper treatment: Obstetrics/Gynecology-related; Named as member of practice, not directly involved in patient's care.

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

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

A. Appointments

Check here if none

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

University of Vermont Burlington, VT

	B.	Teaching		Check here if none
		Please provide information regarding your responsibility education within the past 10 years if not listed.	for teacl	hing graduate medical
		None reported		
39.	<u>Public</u>	ations: [26 VSA § 1368(a)(13)]	Chec	k here if none
	Note: A	Answering #39 is optional. By answering, you are granting ation posted on the web, exactly as provided to the Boar	permiss rd .	sion to have this
	Please	provide information regarding your publications in peer-rest 10 years if not listed.		medical literature within
40.	<u>Activit</u>	ies [26 VSA § 1368(a)(14)]		□ Check here if none
	Note: A	Answering #40 is optional. By answering, you are granting ation posted on the web, exactly as provided to the Boar	permiss <u>rd.</u>	sion to have this
	Please awards	provide information regarding your professional or commutation if not listed.	unity ser	vice activities and
		None reported		
41.	Practic	ee Setting [26 VSA § 1368(a)(15)]		□ Check here if none
	What is	the location of your primary practice setting?		
		BENNINGTON, VT		
42.	Transla	ating Services [26 VSA § 1368(a)(16)]		☐ Check here if none
	Please Are any	identify any translating services available at your primary of translating services available at your primary practice loc	practice ation?	location.
	If yes, p	note a lease describe here the translating services available: Note VES - Person M Indiana. Note Patients [26 VSA § 1368(a)(17)] With Land	pr ore	Her Sarvice
43.	Medica	iid/New Patients [26 VSA § 1368(a)(17)] With Can	gunge	line Services
	Α.	Medicaid participation	<i>y</i> *	
		Do you participate in the Medicaid program?	yes	□ no
	B.	New Medicaid Patients		
		Are you currently accepting new Medicaid patients?	□ yes	≰no

Part V

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

Associate Professor 1990 - present

I hereby affirm that the information provided above is true questions to the best of my knowledge and ability.	and accurate, and that I have answered the
Date:	Eld Llon Ms
* {	Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
Information regarding publications in peer-reviewed medical literature within the last 10 years.
Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State	Year
Circumstances under which license was withdraw terminated	
(Question 18) Voluntarily surrendered or resign - Attach documents	ned a license to practice medicine or any healing a
State	Year
Circumstances	·
(Question 19) Disciplinary charges or action - A	
Name of organization involved	Date
Duration	
Action taken (circle all that apply)	
01 Revocation of right or privilege 02 Suspension of right or privilege 03 Censure 04 Written reprimand or admonition 05 Restriction of right or privilege 06 Non-renewal of right or privilege 07 Fine 08 Required performance of public service 09 Education/Training/Counseling/Monitoring 10 Denial of rights or privilege 11 Resignation	12 Leave of absence 13 Withdrawal of an application 14 Termination or non-renewal of contract 15 Medical Records Suspension 16 Probation 17 Assurance of Discontinuance 18 Consent Agreement 19 Letter of Agreement 20 Expulsion from Membership 21 Reprimand 22 Other (specify)
Circumstances	
Question 20) Denial of examination privileges	- Attach documents
State	Year
	denied

Residency Training Program(s)	
Location of Programs	Year
Circumstances	
(Question 23) Affecting Health Care Institution Staf Attach documents	ff Privileges, Employment or Appointment -
Institution involved	
Location	
Circumstances	
(Question 24) Privilege to prescribe controlled sub	stances - Attach documents
Name of organization involved	
Type of restriction	Date
Circumstances of restriction	

(Questions 26 an	d 28) Criminal Investi	gation - Proceeding - Attach documents
Court		
Status		
Conviction?		Date
Plea?Yes		Date
(Question 27) Inv	estigation by any oth	er licensing board - Attach documents
Name of Licensing	Board	Date
Location of Licensi	ing Board	
Circumstances		
		reatment, use of chemical or illegal substances
Treating organizati	ion	
	•	Telephone
		- field of practice - use of chemical substances
Dates of illness or	dependency	to
Dates of treatment		to
Name of Rehabilita	ation/Professional Assis	stance or Monitoring Program
Address		Telephone
	Program	

(Question 37) Medical Malpractice Claim

in necessary.	
Insurer	
Claimant name	
Description of alleged claim (allegations	only): This does not constitute an admission of fault or liability
5. Narrative of event.	nt;
If the incident resulted in patient's death,	indicate cause of death according to autopsy or patient chart:
Your role (circle one):	
01 Anesthesiologist 02 Primary Care Physician 03 Referring Physician 04 Attending Physician 05 Consultant Specialist 06 Surgeon 07 Fellow 08 PGY 1 09 PGY 2 10 PGY 3	11 PGY 4 12 PGY 5 13 PGY 6 14 PGY 7 15 Workmen's Compensation Evaluator 16 Court Psychiatrist 17 On-Call Physician 18 Group Practitioner/Partner 19 Other: Specify
Your Legal Representative in this matter	(include name, address and telephone number)
Name	
Firm	
Address	
· ·	,
Indicate Decision, Appeal, Settlement, If a Court or Arbitration Panel heard your	Dismissal:
Court	

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used

Court's location
Docket number
Date the action was filed
Decision determined by (check one): Judge Jury Arbitration Panel
Decision: Award:
If your case was appealed, indicate the following: Date appeal filed (month, day, year) /
If your case was settled, indicate the following:
Settlement amount paid on your behalf:
Total settlement amount:
Date of settlement: (month, day, year)/
Case dismissed against you Against all defendants
Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.
Additional information, if any:

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to http://www.atg.state.vt.us/ and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

	of Medical Practice, PO Box 70, Burlington, VT	
I consent:		
Signature	Date	
Name (printed or typed)		
License type (profession)	Vermont License Number	
Mailing Address		
City State 7in		

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I (print name) her include prescription information containing my promoting a prescription drug.	eby revoke my consent to the use of regulat prescriber-identifiable data for the purpose of	ed records which of marketing or
Signature	Date	Tanaman and the same and the sa
Name (printed or typed)		
License type (profession)	Vermont License Number	
Mailing Address		
City, State, Zip		
Please mail your completed form to:		
Board of Medical Practice Vermont Department of Health		

PO Box 70 Burlington, VT 05402-0070

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

- (1) 60 days or fewer have elapsed since the date a judgment was issued; or
- (2) the person is in compliance with a repayment plan approved by the judiciary.

Signature:	Eld Lan	Date: 4)1	Lio
		•	

PLEASE NOTE:

In accordance with 4 V.S.A. §1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support n

by the	supp office	he date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability ort payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an e hardship. (15 V.S.A. § 795)
1.	You	<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.
		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	certifi	Regarding Taxes 13 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the ies 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 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,	You	a <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).
	ū	or I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship". Regarding Unemployment Compensation Contributions
(includi with an unit is i of the d paymer contribi approve	ng a li y emp n goo ate su its in l utions ed by i	8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business icense to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space alloying unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing distanding with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as uch declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any sor payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in butions due and payable would impose an unreasonable hardship.
3. contribi	utions	
	Q /	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.)
	0	I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
		or I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.
Social S	ecurit	ty #* Date of Birth
ne Dep	artme	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 nt 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
certify nformat	that th	he information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false r omission of information is unlawful and may jeopardize my license/certification/registration status.
Signatu	re of	Applicant Edd JM Date 9/1/10

in

Vermont Department of Health, Board of Medical Practice Physician 2010 Renewal License Application (Revised 4/22/10) 7898 18 of 17



Edd Lyon MD 140 Hospital Drive Suite 108 Bennington, VT 05201

righting of examination of the

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:	Octobe	r 1, 2010							and the second s	
Dear P	hysician:	:				State of the state	AND THE PERSON NAMED OF TH	grow print of the contract of	Control of the Data of the Control o	
until th	Your 20 e followin	010 Physician's License ng information is receive	Renewal applica	tion	has been	receive	d by this o	office and	cannot be proces	sed
Applica	Part II	\$500 renewal fee \$25 late fee 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 13 Item 14 Item 15 Item 16 Item 17	Part III Part IV		Item 18 Item 19 Item 20 Item 21 Item 22 Item 23 Item 24 Item 25 Item 26 Item 27 Item 28 Item 29 Item 30 Item 31 Item 32 Item 33 Item 34			Part V	Item 35 Item 36A Item 36B Item 37A Item 37B Item 38A Item 38B Item 39 Item 40 Item 41 Item 42 Item 42 Item 43A Item 43B Date Signature	
Child Si		axes, Unemployment C Number 1 – check one Number 2 – check one Number 3 – check one Sign, Date, SSN, DOB	of the two statem of the two statem	ents ents						
Additior		s opleted form A ement of Good Standing	9							
The	page(s)	that need(s) completion	i (if applicable) is/	/are	attached.	Please	complete	the nece	essarv item(s). inifi	al.

The page(s) that need(s) completion (if applicable) is/are attached. Please complete the necessary item(s), initial, date and return as soon as possible so that processing may be finalized. **The information cannot be faxed.**

Thank you.

Sincerely, Medical Practice Board

Enclosures



Renewal - 042.0006255 Page 1 of 11

Renewal - 042.0006255

Name Edd Gilbert Lyon Credential 042.0006255

Fee Details

Renewal \$500.00 \$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@state.vt.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to Malpractice
- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.

Be sure to submit:

- completed application
- completed Form A, if applicable
- payment in the amount of \$500 to the Vermont Department of Health
- LATE FEE: Applications received after the license expiration date will be assessed a \$25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved
 by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual
 inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:

Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:

Lyon

2. First Name:

Edd

3. Middle Name:

Gilbert

4. Have you ever legally changed your name?

No

5. If yes, enter your former name and other name(s):

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

6. Date of Birth:



7. Enter your MAILING ADDRESS information:

Attention

Street State State

Zip

Country United States

E-mail Address

Telephone Alternate Phone (e.g. Pager)

8. Enter your PUBLIC ACCESS address information:

Attention

Street 339 Dewey Street,

City Bennington

State VT

Zip 05201

Country United States

Telephone (802) 447-1191

E-mail Address

Alternate Phone (e.g.

Pager)

Renewal Part II

9. Were you in active clinical practice in the past 12 months?

Yes

10. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state? No

11. If yes, complete the section below.

	•				
State	Profession	License Number	Issue Date	Expiration Date	Status

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

Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: Albany Medical College State: New York	05/01/1975
Country: United States School Type: Medical School	
Degree:	

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

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

Site Name	End Date	Specialty
University of Oklahoma College of Medicine-Tulsa	01/01/1978	Family Practice

14. <u>Specialty Board Certification</u> [26 VSA § 1368(a)(9)] Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Practice	01/01/1978	01/01/1997
Family Practice	American Board of Family Practice	01/01/1997	01/01/2003
Family Practice	American Board of Family Practice	01/01/2003	12/31/2013

28. State:

15. <u>Years of Practice</u> What year did you start practicing as a medical professional? 1978

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

List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date
Southwestern Med. Ctr.	Vermont	01/01/1978

Southwestern Med. Ctr.	Vermont	01/01/1978
ANY "YES" RESPONSE TO THE QUESTIONS B	ELOW MUST BE	E FULLY EXPLAINED.
Have you ever applied for and been denied a certificate to practice r No	medicine or any c	ther healing art?
18. State:		
19. Year:		
20. Circumstances under which you applied and were denied a certification	te to practice med	dicine or any other healing art:
21. Denied certificate to practice medicine or any other healing art - Uplo	oad documents	
22. Have you ever withdrawn an application for a certificate to practice r	medicine or any o	ther healing art?
23. State:		
24. Year:		
25. Circumstances under which license or certificate was withdrawn, de	nied, revoked, no	t renewed, or otherwise terminated:
26. Please upload any documents you have that are relevant to this mat	tter.	
27. Have you ever voluntarily surrendered or resigned a license or certif disciplinary action or any other reason? No	icate to practice i	medicine or any other healing art in lieu of

29. Year:
30. Circumstances:
31. Please upload any documents you have that are relevant to this matter.
32. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
33. Name of organization involved:
34. Date:
35. Duration:
36. Action Taken (add all that apply):
37. Circumstances:
38. Please upload any documents you have that are relevant to this matter.
39. Have you ever been denied the privilege of taking an examination before any state medical examining board? No
40. State:
41. Year:
42. Circumstances under which examination privileges denied:
43. Please upload any documents you have that are relevant to this matter.
44. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education? No
45. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:
46. Discontinued Education, Training, or Clinical Practice - Upload documents:
47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion? No
48. Training program(s):
49. Location of program(s):
50. Year:

51. Circumstances:
52. Please upload any documents you have that are relevant to this matter.
53. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you? No
54. Institution involved:
55. Location:
56. Year:
57. Circumstances:
58. Please upload any documents you have that are relevant to this matter.
59. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricte by, or surrendered to any jurisdiction or federal agency at any time? No
60. Name of organization involved:
61. Type of restriction:
62. Date:
63. Circumstances of restriction
64. Please upload any documents you have that are relevant to this matter.
65. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice. No
66. Please provide a general description of your practice of internet prescribing:
67. Are you presently, or have you ever been, a defendant in a criminal proceeding? No
68. Court:
69. City and state:
70. Charge:
71. Description:

72. Status:
73. Date:
Renewal Part III
PART III
(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)
Any "yes" response to the questions below must be fully explained.
74. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?
75. Licensing or certification board:
76. Date:
77. Location of Licensing Board:
78. Circumstances:
79. Please upload any documents you have that are relevant to this matter.
MEDICAL DEFINITIONS
The following definitions are provided to assist you in answering the medical related questions:
"Ability to practice medicine" - This term includes:
The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments, and
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
 The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.
"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant

- licensee.
- "Chemical substances" This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
- "Controlled substances" This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).
- "Illegal use of controlled substances" This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled

Substances Act or other provisions of federal law.

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

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

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

- 84. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.
- 85. Please upload any documents you have that are relevant to this matter.
- 86. Are you currently engaged in the illegal use of controlled substances?

- 87. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.
- 88. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

- 89. Treating organization:
- 90. Address:
- 91. Telephone:
- 92. Type of diagnosis, condition or treatment field of practice use of chemical substances:
- 93. Dates of illness or dependency (from, to):
- 94. Dates of treatment (from, to):
- 95. Name of rehabilitation/professional assistance or monitoring program:
- 96. Address:
- 97. Telephone:
- 98. Contact person at Program:

Renewal - 042.0006255 Page 8 of 11

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

Renewal Part IV

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can.

99. <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

100. <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
--------------------	---------------------	------	-------	-------------

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

Have there been any charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction?

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

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

Date of Charges	Court	City	State	Description of Charges
		,		

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

Have there been any formal charges served, findings, conclusions, and/or orders of the Board of Medical Practice (including stipluations), and/or final disposition of such matters by the courts, if appealed?

No

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

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

Date Final Disposition Summary

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

Have there been any formal charges served against you by licensing or certification authorities of other states? No

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

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

	Date of Disposition	Licensing Authority	City	State	Description of Disposition
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Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

107. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?
No

108.

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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
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109. Have your hospital privileges ever been restricted, or have you ever resigned or not renewed your medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital?

110.

B. Other Restrictions

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

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement
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111. <u>Medical Malpractice Court Judgments/Settlements</u> [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.

Ye

112.

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Date of Judgment

113

<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	
05/17/2005	

Medical Malpractice Claim

For each response provided in the previous Medical Malpractice Judgements and/or Settlements questions you must complete the form located **here**. Please download the form, complete it for each response, and then upload to each respective response. **This information is required for each and every response provided for Judgements and/or Settlements.**

Appointments/Teaching [See 26 VSA § 1368(a)(12)]

Note: Providing the following Appointments and Teaching information is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

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

School	City	State	The second secon	Year Started	Year Ended
University of Vermont College of Medicine	Burlington		Medical Student Community Preceptor	2000	

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

School/Institution City State Nature of Teaching Year Started Year Ended	
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116. Publications [See 26 VSA § 1368(a)(13)]

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

	-	
Title	Publication	Publication Date

117. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering this guestion 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.

I		
IActivity or Award		
IActivity or Award		

118. Provide the following information for each practice location. Be sure to indicate which is to be your primary practice location.

Practice Name	City		Primary Practice	Languages		Accepts New Medicaid Patients?
Bennington Family Practice	BENNINGTON	Vermont	Yes		Yes	Yes

Statement of Good Standing

119.

State of Vermont Department of Health Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that either:

- A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or
- B. I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

- 1. 60 days or fewer have elapsed since the date a judgment was issued; or
- 2. the person is in compliance with a repayment plan approved by the judiciary.

Yes

120. Date: 10/23/2012

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

121. You <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)

122. You must select one of the two statements below regarding taxes:

I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both.)

The disclosure of your social security number is manditory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

123. Social Security Number:



124. Date of Birth:



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

Yes

126. Date: 10/23/2012

Renewal Payment

127. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.

Self / Credit Card

Review

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Renewal - 042.0006255

Name Edd Gilbert Lyon Credential 042.0006255

Fee Details

Renewal \$500.00 \$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4223, 800-745-7371 or medicalboard@state.vt.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.
- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to Malpractice

<u>Malpractice Claim Documentation</u> – If you have reportable malpractice history, you must download Form A, carefully complete a form for each case, and submit it along with the required documentation. For your application, reportable malpractice includes:

- O Pending claims that have not been resolved.
- Cases that resulted in a payment by you or on your behalf, whether as a settlement, arbitration award, or court verdict.
- Note that you need not report cases that were resolved in your favor with no payment by you or on your behalf. This
 includes cases that were withdrawn without payment, dismissed without payment, or resolved by a verdict in your
 favor.

Be sure to submit:

- o completed Form A, if applicable
- o payment in the amount of \$500 to the Vermont Department of Health
- O LATE FEE: Applications received after the license expiration date will be assessed a \$25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously
 approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to
 correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any
 change or new information including, but not limited to, disciplinary or other action limiting or conditioning their
 license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the
 Board.

Thank you.

Renewal Part I

Name

Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you

must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:

Lyon

2. First Name:

Edd

3. Middle Name:

Gilbert

4. Have you ever legally changed your name?

No

5. If yes, enter your former name and other name(s):

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

6. Date of Birth:



7. Please provide your preferred email address for receiving important correspondence from this medical board



8. Enter your MAILING ADDRESS information:

Attention
Street
City

State

Zip

Country United States

E-mail Address

Telephone Alternate Phone (e.g. Pager)

9. Enter your PUBLIC ACCESS address information:

Attention

Street 339 Dewey Street,

City Bennington

State VT

Zip 05201

Country United States

Telephone (802) 447-1191

E-mail Address

Alternate Phone (e.g.

Pager)

Renewal Part II

10. Were you in active clinical practice in the past 12 months?

Yes

11. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state?

12. If yes, complete the section below.

State Profession License Number	Issue Date	Expiration Date	Status
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13. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation.

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

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

Site Name	End Date	Specialty
University of Oklahoma College of Medicine-Tulsa	06/01/1978	Family Practice

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

Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Practice	01/01/1978	01/01/1997
Family Practice	American Board of Family Practice	01/01/1997	01/01/2003
Family Practice	American Board of Family Practice	01/01/2003	12/31/2013
Family Practice	American Board of Family Medicine	04/17/2013	04/01/2023

16. Years of Practice

What year did you start practicing as a medical professional?

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

List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date	End Date
Southwestern Med. Ctr.	Vermont	08/01/1978	

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

18. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art in any
jurisdiction? If yes, identify the US state or territory, or Canadian territory or province that denied the application and the year in
which it was denied, and provide a summary of the circumstances and reason for denial, in the following questions. Upload
documents related to the denial where indicated

Nο

19. State:

20. Year:

- 21. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:
- 22. Denied certificate to practice medicine or any other healing art Upload documents
- 23. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art, in any jurisdiction? If yes, identify the US state or territory, or the Canadian territory or province in which you withdrew the application and the year in which it was withdrawn, and provide a summary of the circumstances and reason for the withdrawal, in the following questions. Upload documents related to the withdrawal where indicated.

No

24. State:

25. Year:

26. Circumstances under which the application for license or certificate was withdrawn, specifying your reason or reasons for withdrawl
27. Withdrawal of application for license or certificate - Upload documents:
28. Have you ever voluntarily surrendered a license or certificate to practice medicine or any other healing art, in any jurisdiction, after having been notified of an investigation that had not yet been resolved or in lieu of disciplinary action? "Surrendered a license" includes any form of voluntary abandonment of the right to practice in a jurisdiction, regardless of the terminology used, and includes allowing a license to lapse after learning of an investigation by a licensing authority. If yes, identify the state, territory, or province in which you surrendered a license or certificate and the year in which it was surrendered or you resigned, and provide a summary of the circumstances in the following questions. Upload documents related to the surrender of license where indicated. NOTE: If you let a license lapse because you no longer practiced in a state, and you had no knowledge of a pending investigation by the licensing authority, that would not constitute surrender of your license.
29. State:
30. Year:
31. Circumstances:
32. Voluntary surrendered license or certificate to practice medicine or any other healing art - Upload documents:
33. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions. If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated. No
34. Name of entity involved:
35. Date:
36. Duration:
37. Action Taken (add all that apply):
38. Circumstances:
39. Disciplinary charges or actions - Upload documents:
40. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated. No
41. State:
42. Circumstances surrounding denial of examination privileges and reason therefore provided by the board that denied you the privilege of taking an exam:
43. Denial of examination privileges - Upload documents:

44. Have you ever discontinued your education, training, or medical practice for a period of more than three (3) months, NOT including periods occurring solely during premedical education? No
45. If yes, please explain, including the dates during which your education, training, or practice was discontinued.
46. Discontinued Education, Training, or Clinical Practice - Upload documents:
47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion? No
48. Training program(s):
49. Location of program(s):
50. Year:
51. Circumstances surrounding dismissal, suspension, or request for you to leave the training program(s) before completion?
52. Are you currently the subject of an investigation or peer review by any licensing authority, hospital, medical staff group, health care facility, professional association, or other body that has authority to take actions regarding: your right to practice medicine or any other healing art; your employment practicing medicine or any other healing art; or your professional qualifications (e.g., specialty board certification)? If yes, provide the name of the entity conducting the investigation, its location, the date you learned about the investigation, and the circumstances that triggered the investigation in the following questions and upload any relevant documentation you have such as a letter notifying you of the investigation where indicated.
53. Entity Investigating:
54. Location of entity investigating:
55. Date (month and year) your learned of the investigation?
56. Describe the event under investigation and the circumstances triggering the investigation:
57. Open investigation by licensing authority, hospital, medical staff group, health care facility, professional association, or professional certifying organization – upload documents.
58. Has your privilege to possess, dispense, administer, or prescribe controlled substances or other prescription medications or devices ever been suspended, revoked, denied, restricted, or surrendered as the result of an investigation or action by any governmental entity at any time? If yes, provide the entity that acted on your privilege to prescribe, the nature of the limitation or action, the date of the action, and a description of the circumstances underlying the action in the following questions, and upload any relevant documentation you have regarding the action where indicated. No
59. Entity that took action on prescribing privileges:
60. Action taken:
61. Date of action taken regarding prescribing privileges:

62. Circumstances underlying action on prescribing rights:
63. Action taken on prescribing privileges – upload documents.
64. Are you presently a defendant in a criminal proceeding? No
65. Court:
66. City and state:
67. Charge:
68. Description:
69. Status:
70. Date:
71. Defendant in criminal proceeding - Upload Documents:
72. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing fo patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions. No
73. If you answered yes to the preceding question, provide a general description of any prescribing you do in response to electronic communications.
Renewal Part III
PART III
(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)
Any "yes" response to the questions below must be fully explained.
74. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.
75. Jurisdiction:
76. Description of matter under Investigation:
77. Date you became aware of Investigation:

- 78. Upload any documents you may have relating to the matter under investigation:
- 79. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and a description of the matter under investigation in the following questions and upload relevant documents where indicated.



- 80. Licensing or certification board conducting investigation:
- 81. Date of event(s) under investigation:
- 82. Nature of event(s) under investigation:
- 83. Pending licensing board investigation upload documents.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

- "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
 - 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.
- 84. 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?



- 85. 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.
- 86. Please upload any documents you have that are relevant to this matter.
- 87. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to

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practice medicine in your field of practice with reasonable skill and safety?

	Statutory Profile Questions
R	Penewal Part IV
	102. Contact person at Program:
	101. Telephone:
	100. Address:
	99. Name of rehabilitation/professional assistance or monitoring program:
	98. Dates of treatment (from, to):
	97. Dates of illness or dependency (from, to):
	96. Type of diagnosis, condition or treatment - field of practice - use of chemical substances:
	95. Telephone:
	94. Address:
	93. Treating organization:
	Medical condition, treatment, use of chemical or illegal substances:
	92. Please upload any documents you have that are relevant to this matter.
	91. 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.
	90. Are you currently engaged in the illegal use of controlled substances?
	89. Please upload any documents you have that are relevant to this matter.
	88. 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.

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

Applicants with other events or actions that must be reported (e.g., a criminal conviction) must provide documentation of each event. It is very important for the Board to receive copies of court papers, licensing authority decisions, or similar documentation, as noted below. The Board will not act on an application that lacks required documentation. If any reportable event involves alcohol or drugs in any way, you must contact the Vermont Practitioner Health Program to arrange for an evaluation. The Board will not act on an application that is missing a required evaluation. You may contact VPHP at (802) 223-0400. Information about VPHP is online at: http://www.vtmd.org/health-professional-wellness-and-recovery-programs.

103. <u>Criminal Convictions</u> [See 26 VSA § 1368(a)(1)] Have you been convicted of any crime? This includes both misdemeanors and felonies; it includes crimes such as driving under the influence (DUI), but not non-criminal traffic offenses such as speeding or parking tickets. For purposes of this question, "convicted" means that you pleaded guilty or were adjudged guilty by a court of competent jurisdiction. For this question, it also includes the loss of a driver's license as a result of a civil process triggered by the refusal to provide a sample of breath for the purpose of screening for driving while under the influence of alcohol.

N٥

104. <u>Criminal Convictions continued</u> [See 26 VSA § 1368(a)(1)] Provide information regarding each conviction as defined above. In addition to entering the information here, you must submit copies of documents that show information about the crime (s) of which you were convicted and the sentence imposed, to include the police report, any ticket/citation/indictment/arrest record, and final disposition.

Date of Conviction	Court of Conviction	City	State	Description
--------------------	---------------------	------	-------	-------------

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

Have you ever had a criminal involvement that resulted in a case resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

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

Provide information regarding each criminal involvement resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges
-----------------	-------	------	-------	------------------------

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

Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

Nο

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

Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date Final Disposition Summary

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

Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

Νo

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

Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition Licensing Authority City State Description of Disposition	
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Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

111. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?
No

112

A. Revocation or Restriction of Hospital Privileges Information

Provide information about each instance in which hospital privileges were revoked or involuntarily restricted for reasons related to competence or character. Provide documentation that shows the date, basis for the action, the authority who took the action, and the action taken.

Date of Restriction Hospital Name State Nature of Restriction Reason for Restriction

113. Have you ever, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character, done any of the following:

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?

No

114. B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information

Provide information about each instance in which you resigned or did not renew medical staff membership, or you had hospital privileges restricted, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character? Provide documentation that shows the date, the hospital, the basis for and nature of the case, and the terms of settlement, if any.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement
------	---------------	-------	--------	------------------	--------------------------

- 115. Medical Malpractice Court Judgments & Settlements Have you ever had a medical malpractice claim against you that is still pending or that resulted in any of the following:
- a court judgment against you; or
- an arbitration award or a settlement that you or another party paid on your behalf?

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located **here** Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.

Yes

116. A. Judgments

Provide the information requested in the following table for each case in which there was a court judgment or arbitration award against you.

Date of Judgment Number of Judgments	
Pato of Gadgmont	

117. B. Settlements

Provide the information requested in the following table for each case in which you were named as a defendant and in which a settlement was paid by you or on your behalf.

Date Of Settlement
08/22/2000
05/17/2005

118. C. Pending Cases

Provide the information requested in the following table for each case that is currently pending against you.

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п	210

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.)

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

School	City	State	Nature of Appointment	Year Started	Year Ended
University of Vermont College of Medicine	Burlington	Vermont	Clinical Assistant Professor	1995	

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

School/Institution City Sta	Nature of Teaching	Year Started Year Ended	- 1
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121. Publications [See 26 VSA § 1368(a)(13)]

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date
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122. 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
Volunteer at the Bennington Free Clinic

123. Provide information about each current and planned practice location, wherever located. Indicate which is planned to be your primary practice location.

Practice Name	City		Primary Practice	Languages		Accepts New Medicaid Patients?
Bennington Family Practice	BENNINGTON	Vermont	Yes		Yes	Yes

Statement of Good Standing

124

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

125. Date:

10/22/2014

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)

126. 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)

127. 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 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.

128. Social Security Number:



129. Date of Birth:



130. 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

131. Date: 10/22/2014

Continuing Medical Education Requirements

Each applicant for renewal must certify that he or she meets the requirements for CME as indicated by one of the statements below, a – f. Note that for purposes of this certification, completion of an activity includes taking the steps necessary to receive credit and obtain documentation of completion. If you cannot certify that you are eligible to renew your license because one of the statements applies to you, then you must contact the Board of Medical Practice to discuss your renewal application. You are not required to submit documentation of your CME activities with your renewal application, but licensees are subject to audit and may be asked to submit such documentation during the next two licensing cycles (for this renewal, through November 30, 2018).

The Rules for Continuing Medical Education are available on the Board's website at: http://healthvermont.gov/hc/med_board/documents/FinalCMERules10.1.12_000.pdf

- a) I do not have to complete CME for this renewal because I was licensed as an MD in Vermont for the first time on or after December 1, 2013.
- b) I was licensed as an MD for the first time in Vermont between December 1, 2012 and November 30, 2013. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

- c) I have completed at least 30 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances.
- d) I am a member of the armed forces of the United States and I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) one year or more. Accordingly, I am not required to certify that I completed CME for this renewal.
- e) I am a member of the armed forces of the United States and during the period from June 1, 2012 to November 30, 2014, I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) less than one year. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.
- f) I have not completed the required CME for renewal, but I have submitted a make-up plan that I have signed and that was approved by the Executive Director of the Board.
- 132. I hereby certify that I have satisfied the Vermont Board of Medical Practice requirements for CME as indicated in the above statement. Select the one that best applies.

С

Workforce Survey

"Since 1999, the State of Vermont has been conducting a census of some professions every two years as part of relicensing. This has allowed us to monitor changes in Vermont's health care workforce. In 2012, the Legislature enacted a law to make work force data collection mandatory for all health care professions at license renewal as a necessary part of health care reform and planning for our health care future. We would like to thank you for your participation in this census."

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**

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

Renewal Payment

134. 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