RENEWAL APPLICATION

I hereby apply for the renewal of my license AS
A Physician
for the period from 02/01/1987 to 01/31/1989

under the provisions of Title 26 Chapter 23 V.S.A. LICENSE NUMBER 42-0006255
I enclose the correct fee as follows $ 100.00

IMPORTANT: YOU MUST SIGN THE REVERSE SIDE OF THIS CERTIFICATE OR YOUR LICENSE WILL NOT BE RENEWED

LYON EDD G MD

140 HOSPITAL DRIVE
BENNINGTON VT 05201

SPECIAL INSTRUCTIONS

DURING THE PREVIOUS 2 YEARS, HAVE YOU: A YES REQUIRES AN EXPLANATION
please circle either yes or no

Had any treatment for mental illness? [redacted]
Had any convictions other than minor traffic violations? YES/NO [redacted]
Had an addiction to or been treated for drug or alcohol abuse? YES/NO
Had another state deny or take action against your license? YES/NO
Had any final unfavorable liability judgements or settlements? YES/NO
Had any hospital priveleges denied, conditioned or revoked? YES/NO
Recently started practicing in VT? YES/NO Specify Date.

1/29/87

Edd G. Lyons MD

RENEWAL APPLICATION

Pd. 96
1/16/89

I hereby apply for the renewal of my License AS

A Physician

for the period from 02/01/1989 to 11/30/1990

under the provisions of Title 26 Chapter 23 V.S.A. LICENSE NUMBER 42-0006255

I enclose the correct fee as follows: $ 96.00

IMPORTANT: YOU MUST SIGN THE REVERSE SIDE OF THIS CERTIFICATE OR YOUR LICENSE WILL NOT BE RENEWED

LYON EDD G MD

140 HOSPITAL DRIVE
BENNINGTON VT 05201

P8/8/1

READ REVERSE FIRST

SPECIAL INSTRUCTIONS

DURING THE PREVIOUS 2 YEARS, HAVE YOU: A YES REQUIRES AN EXPLANATION
please circle either yes or no

Had any treatment for mental illness? [redacted]
Had any convictions other than for minor traffic violations? Y[redacted]
Had an addiction to or been treated for drug or alcohol abuse? [redacted]
Had any jurisdiction deny or take action against your license? YES NO
Had any final liability judgments or settlements? YES NO
Had any hospital privileges denied, conditioned or revoked? YES NO
Recently started practicing in Vermont? YES NO
to distribute workload renewal period has been adjusted & fee prorated

[illegible] certifies that he or
[illegible] due, the tax
[illegible] by the Commissioner of
[illegible] impose an unreasonable

[illegible] with respect to or in full
[illegible] of this application.

1/6/89 [illegible]

[illegible] need to check with us

[illegible] address or name.

STATE OF VERMONT
RENEWAL APPLICATION

I hereby apply for the renewal of my: Physician License

EDD G LYON MD

140 HOSPITAL DRIVE
BENNINGTON VT 05201

Current Expiration	Renewal Period Covering	Renewal Fee	Lic/Cert #
11/30/90	12/01/90 - 11/30/92	150.00	42-0006255

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? [redacted]
Had any convictions other than for minor traffic violations? YES/NO [redacted]
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

You must sign the reverse side or your license will not be renewed

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

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

OCT 1992 VERMONT BOARD of Medical Practice

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

42-0006255 A

Edd Gilbert Lyon MD

140 Hospital Drive
Bennington VT 05201

****

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

SECTION I

1. Name: EDD G. LYON 2. Vermont License Number: 42- 0006255

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

4. Home Address: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: 140 HOSPITAL DR. X

City, State, Zip Code: BENNINGTON, VT. 05201

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

7. Date of Birth: Month: [redacted]

8. Place of Birth: [redacted] 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 Graduation: 1969

Degree Granting Institution: HAMILTON COLLEGE Location: CLINTON, N.Y.
First Institution (If transfer): ____ Location: ____

12. Medical Degree - Circle: (M.D.) Other: ____ Year of Graduation: 1975

Degree Granting Medical School: ALBANY MED. COLLEGE Location: ALBANY, N.Y.

First Medical School (If transfer): UNIVERSIDAD AUTONOMA Location: GUADALAJARA, MEXICO

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

13. Do you have hospital privileges **in Vermont?** ✓ Yes ____ No

Name(s) and Location(s) of Hospital(s): SOUTHWESTERN VT. MEDICAL CENTER
BENNINGTON, VT.

14. Did you practice in Vermont during the past 12 months? ✓ Yes ____ No

15. Other states where you now hold an active license to practice: ____

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

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

Specialty(ies) & Subspecialty(ies)	American Specialty Board Certified (Yes or No)	
(a) FAMILY PRACTICE	✓ Yes ____ No	Year Certified/Recertified: 78 / 90
(b) ____	____ Yes ____ No	Year Certified/Recertified: ____ / ____
(c) ____	____ Yes ____ No	Year Certified/Recertified: ____ / ____

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

Institution	City	State	Degree	Year
(a) ALBANY MEDICAL COLLEGE	ALBANY	N.Y.	MD	1975
(b) ____	____	____	____	____

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

Institution	City	State	Specialty	Year Completed
(a) UNIV. OF OKLA.	TULSA	OKLA.	FAMILY PRAC.	1978
(b) ____	____	____	____	____
(c) ____	____	____	____	____

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

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

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

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

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

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

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

SECTION II CONTINUED

6. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? ___ YES ✓ NO

7. Has any medical malpractice claim been made against you in the last ten years (whet[redacted] 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? ___ YES ✓ 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? ___ YES ✓ NO

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

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

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

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

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) 8/78

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

SECTION III CONTINUED

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

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

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

6. Practice Site Number One
Street Address: 140 HOSPITAL DR.
Town: BENNINGTON Zip: 05201
Please complete **one full line for each specialty** (example: pediatrics) that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
FAMILY PRACTICE	30	2	NO	YES	30%	YES	30%	YES

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

7. Practice Site Number Two
Street Address: 6 ROBERTS NORTH Town: RUTLAND Zip: 05701 *
Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
GYNECOLOGY	3	3	NO	YES	15%	YES	0	YES

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

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

SECTION III CONTINUED

8. Practice Site Number Three
Street Address: BENNINGTON COLLEGE
Town: BENNINGTON Zip: 05201
Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
~~STUDENT HEALTH~~ FAMILY PRACTICE	3	8	No	YES	0	YES	0	YES

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

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

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

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

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

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

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

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

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

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT

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

STATEMENT OF APPLICANT

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

Social Security Number [redacted]
The disclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405(c)(2)(C), and will be used by the Department of Taxes in the administration of Vermont tax laws, to identify individuals affected by such laws.

Date: 10/9/92 **Signature:** Edd Lyon

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

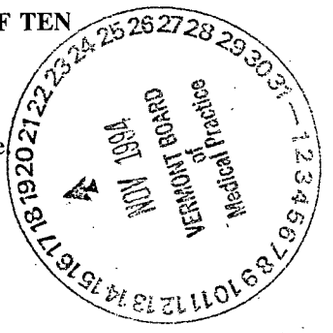
Vermont Board of Medical Practice
109 State Street
Montpelier, Vermont 05609-1106

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

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

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

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.)

1. Name: Lyon , Edd Gilbert

2. Vermont License Number: 42-6255

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

4. Home Address: ~~140 Hospital Drive~~ [redacted]

City, State, Zip Code: Bennington , VT 05201

5. Office Address: 140 Hospital Dr.

City, State, Zip Code: Bennington, Vt. 05201

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

6. Daytime Telephone Number: (802)447-1191

7. Date of Birth: [redacted]

8. Place of Birth: [redacted]

9. Sex (M/F): M

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

SECTION I CONTINUED

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

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

Major Course of Study: Biology

Degree Granting Institution: HAMILTON COLLEGE

Location: CLINTON , NY USA

First Institution (If transfer):_____

Location:_____

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

Degree Granting Medical School: ALBANY MEDICAL COLLEGE

Location: ALBANY , NY USA

First Medical School (If transfer): Universidad Autonoma De Guadalajara

Location: Guadalajara, Mexico

13. Do you have hospital privileges **in Vermont**? ✓ Yes ___ No
Name(s) and Location(s) of Hospital(s):
Southwestern Vt. Medical Center
Bennington, Vt

14. Did you practice in Vermont during the past 12 months? ✓ Yes ___ No

15. Other states where you hold an active license to practice:_____

16. States where you previously were licensed to practice: Okla.

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

	Specialty Code(s) (See the list of specialty codes.)	**American Board of Medical Specialties Certified (Yes or No)**	**Year Certified/Recertified**
(a)	6 0 1	Yes	1978, 1991
(b)			/
(c)			/

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

SECTION I CONTINUED

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

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

SECTION I CONTINUED

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

	Institution	City	State	Country	Specialty Code (See attached list of specialty codes)	Year Completed
(a)	Univ. of Okla	Tulsa	Okla	USA	6 0 1	1978
(b)						
(a)						

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

Name of P.A.	Check if: Primary	and/or Secondary
Paul Grather	✓	

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

SECTION I CONTINUED

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

see previous

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 ability to practice medicine or to function as a student of medicine, resident or fellow? [redacted]

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

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

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

5. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? ___YES ✓NO

6. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in re claim/complaint/demand for damages)? [redacted]

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

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

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

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

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

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

13. Have you been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ✓YES ___NO

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

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

SECTION II CONTINUED

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

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

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

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

SECTION III

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

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

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

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

OR

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

(2) APPLICANT'S STATEMENT REGARDING TAXES (See Explanation Below)

✓ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.)

OR

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

(3) SOCIAL SECURITY NUMBER [redacted]

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

(4) STATEMENT OF APPLICANT

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

Date: 11/7/94 **Signature:** Edd Lyon MD

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

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

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

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

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

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

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

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

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SECTION IV

To be completed only by physicians practicing in Vermont.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

(Section IV is especially for the needs of health care access planning/physician recruitment and retention efforts in Vermont.)
***Note:** If you are retired or are not practicing in Vermont, do not complete Section IV.

1. Current Status (please check one): ✓ 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) 8 / 78

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
   (Month/Year) 8 / 78

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

6. What is your Unique Physician Identification Number (UPIN)? DO 3181

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

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

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

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

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): Bennington Family Practice
Street Address: 140 Hospital Dr.
Town: Bennington, VT Zip Code: 05201

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

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
601	40	2	Yes	Yes	No	Yes
601	6-8	10	"	"	"	"

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	5
✓	General adolescent medical Care	<5
✓	General adult medical care	15
✓	General geriatric medical care	10
✓	General gynecological medical care	5
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): Bennington College
Street Address: _____
Town: Bennington, VT. Zip Code: 05201

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

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
601	~~43~~	5	Yes	Yes	Yes	No

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

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
✓	General adult medical care	2
	General geriatric medical care	
✓	General gynecological medical care	1
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): Planned Parenthood
Street Address: 6 Roberts North
Town: Rutland, Vt. Zip Code: _____

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

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
601	3	4	Yes	Yes	Yes	Yes

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

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): _____

Street Address: _____

Town: _____ Zip Code: _____

Is your practice at this site affiliated with an **IPA HMO**? ___Yes ___No

Is your practice at this site affiliated with a **Group/Staff HMO**? ___Yes ___No

Do you engage in **teaching** at this site? ___Yes ___No

Do you engage in **research** at this site? ___Yes ___No

Is your **personal** income from this practice site based on (check as many as apply):

___Salary ___Fee for service ___Capitation ___Cost based ___ Other (please specify)_____

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

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

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

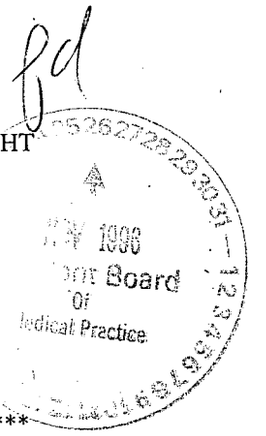
SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new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

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

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

42-6255 LYON, EDD G.

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



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

EDD G. LYON
140 HOSPITAL DRIVE
BENNINGTON, VT 05201

****

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

SECTION I

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

1. Name: EDD GILBERT LYON

2. Vermont License Number: 42-6255

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

4. Home Address: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: 140 HOSPITAL DRIVE

City, State, Zip Code: BENNINGTON, VT 05201

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

6. Daytime Telephone Number: (802)447-1191

7. Date of Birth: [redacted]

8. Sex (M/F): M

9. Are you currently active in clinical practice in Vermont? X Yes ___No

42-6255 LYON, EDD G.

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

SECTION I CONTINUED

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

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

Major Course of Study: BIOLOGY

Degree Granting Institution: HAMILTON COLLEGE

Location: CLINTON, NY . USA

First Institution (If transfer): _____

Location: _____

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

Degree Granting Medical School: ALBANY MEDICAL COLLEGE

Location: ALBANY, NY USA

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

Location: GUADALAJARA, MEXICO

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

(a) SOUTHWESTERN VT. MEDICAL CENTER

(b) _____

(c) _____

(d) _____

(e) _____

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

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

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

SECTION I CONTINUED

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

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

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

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

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

SECTION II: PLEASE CHECK YES OR NO.
A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.
(Section II is for the reporting of information, which is retained solely by the Board of Medical Practice and is **not** part of the data base maintained by the Department of Health.)

During the past two years:

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

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

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

4 Have you been dependent upon alcohol or drugs?

5. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? ___YES ✓NO

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

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

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

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

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

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

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

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

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

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

SECTION II CONTINUED

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

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

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

SECTION III

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

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

Regarding Child Support

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

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

__✓__ I hereby certify that as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

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

Regarding Taxes

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

2. You must check one of the two statements below:

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

or

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

(continued on page 8)

YOU MUST COMPLETE OTHER SIDE

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

SECTION III CONTINUED

Regarding Unemployment Compensation Contributions

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

3. **You must check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:**

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

or

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

4. **SOCIAL SECURITY NUMBER** [redacted] DATE OF BIRTH: [redacted]

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

5. **STATEMENT OF APPLICANT**

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

Date: 11/16/96 Signature: Edward Lyon MD

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

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

QUESTIONS?: (802) 828-2673

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

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

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

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

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

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

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

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

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(a). WORK SITE: NUMBER ONE

Town: BENNINGTON County: BENNINGTON

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

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

PRACTICE SETTINGS

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

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

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

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	0601	FAMILY PRACTICE	48
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

Are you working with physician's assistants and/or nurse practitioners at this site? _✓_Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _1_

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(b). WORK SITE: NUMBER TWO

Town: BENNINGTON County: BENNINGTON

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

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

PRACTICE SETTINGS

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

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

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

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	0601	FAMILY PRACTICE	3
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

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

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(c). WORK SITE: NUMBER THREE

Town: RUTLAND CITY County: RUTLAND

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

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

PRACTICE SETTINGS

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

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

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

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	0601	FAMILY PRACTICE	3
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

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

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(c). WORK SITE: NUMBER FOUR

Town: _____ County: _____

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

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

PRACTICE SETTINGS

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

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

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

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

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

Will you accept new patients at this site? ___Yes ___No

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

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

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

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

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

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

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

Your Name: EDA LYON **Vermont License Number:** 42-6255

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

Insurer: Planned Protection Insurance Company, Ltd.

Claimant Name: CHUN HUA LEE and DAU MIN LEE

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

Basis Code: T 5 D Basis Code: ____ ____ ____

Basis Code: T D 2 Basis Code: ____ ____ ____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

1) Pregnant at approximately 6-7 wk gestation and otherwise healthy

2) Uterus perforated and patient found to have ectopic pregnancy both of which were surgically repaired without complication

3-4) I performed therapeutic abortion which led to perforation. Informed consent was obtained by clinic personnel but claimant claims not to have understood.

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

Incident Location (circle one):

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

Section A continued on next page

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

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 6) CONTINUED

Your Role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
(06 Surgeon)	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

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

Name: S. Crocker Bennett, II

Firm: Paul, Frank & Collins, Inc.

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

City, State, Zip: Burlington, Vt. 05402

Telephone Number: (802) 658-2311

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): ✓ Judge _____ Jury _____ Arbitration Panel
Decision: Allegation T5D dismissed Award: _____
T8Z still pending
If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: ____/____/____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) ____/____/____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

_____

_____

_____

Table I for Section A on the next page

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

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

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

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

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

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

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

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

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

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

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

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

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

Court: _____ Charge: _____ Date: _____

Description: _____

_____

_____

_____

Status: _____
Conviction?: _____ Date: _____
Plea?: _____ Date: _____

SECTION C: DISCIPLINARY CHARGES OR ACTION (QUESTION 5) - ATTACH DOCUMENTS

Name of Organization Involved: _____ Date: _____

Duration: _____

Action Taken (circle all that apply):

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial or right or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other Specify: _____

Circumstances: _____

_____

_____

_____

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

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

_____

_____

_____

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

State: _____ Year: _____

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

_____

_____

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

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

_____

_____

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: _____

Address: _____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

_____

_____

Dates of Illness/Dependency: _____ 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

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

Institution Involved: _____

Date: _____

Circumstances: _____

_____

_____

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

State: _____ Year: _____

Circumstances: _____

_____

_____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

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

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____

_____

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

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

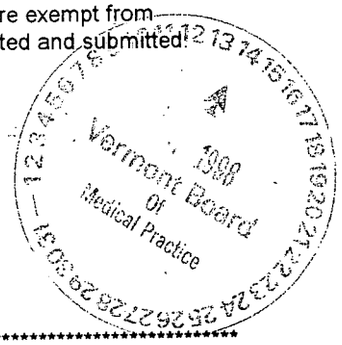
_____

_____

ENTERED NC Pd

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

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



042-0006255

Edd Gilbert Lyon MD
140 Hospital Drive
Bennington, VT 05201

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

SECTION I

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

Vermont License Number: 042-0006255

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

Mailing Address: [redacted] 140 HOSPITAL DR
(Street)

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

Office Address: 140 HOSPITAL DR
(Street)

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

Home Address: [redacted]

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

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

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

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

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

SPECIALTY

Specialty: FAMILY PRACTICE

Subspecialty: ____

American Specialty Board Certified? X Yes ____ No

Specialty?: FAMILY PRACTICE Year Certified?: 1978

If applicable, year recertified? ____

Subspecialty Certificate?: ____ Year Certified? ____

If applicable, year recertified? ____

PRACTICE

Do you have hospital privileges? X Yes ____ No

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

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

OTHER LICENSES

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

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

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

SECTION II

SECTION II - "Yes" answers to Questions 1 - 24 require an explanation on the enclosed Form A.
Important note regarding the following questions: "Yes" answers on past renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1998-2000 period if the answer to any of the questions on the next two pages changes from "No" to "Yes". (Section II is for the reporting of information which is retained solely by the Board of Medical Practice and is not part of the data base maintained by the Department of Health.)

During the past two years:

1. Have you applied for and been denied a license to practice medicine or any healing art? ___Yes _X_ No

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

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

4. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? ___Yes _X_ No

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

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

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

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

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

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

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

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

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

14. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? ___Yes_X_ No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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," [redacted]

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

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

Applicant's Statement Regarding Child Support

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

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

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

or

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

Applicant's Statement Regarding Taxes

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

2. **You must check one of the two statements below:**

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

or

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

Applicant's Statement Regarding Unemployment Compensation Contributions

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

3. **You must check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:**

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant Edd Tyler Date 10/5/98

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

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

Your Name: EDD GILBERT LYON

MEDICAL MALPRACTICE CLAIM (QUESTION 12) You will need TABLE I on Page 3 to complete this section.
Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insurer: PHICO

Claimant Name: Rachel Middlestadt

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

Basis Code: T 4 4 Basis Code: _____

Basis Code: _____ Basis Code: _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

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

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

Incident Location (circle one):

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

Question 12 continued on next page

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

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

Your Role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	(18) Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

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

Name: S CROCKER BENNETT

Firm: Paul, Frank, & Collins, Inc.

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

City, State, Zip: Burlington, VT. 05402

Telephone Number: (802) 658-0042

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

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

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of Settlement: (Month, Day, Year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

_____

_____

_____

Table I for Question 12 on the next page

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

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

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

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

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

Improper Treatment: Anesthesia Related
T07 Failure to obtain informed consent/exceeding consent obtained
T08 Failure to take adequate patient history
T09 Failure to monitor
T10 Failure to test equipment/improper use of equipment
T11 Improper intubation
T12 Improper positioning
T13 Wrong amount/type of anesthesia prescribed

T14 Allergic/adverse reaction
T15 Teeth damage
T16 Other Specify: _____

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

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

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

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

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

Improper Treatment: Specified Procedures
T73 Angiography
T74 Arteriography
T75 CAT scan

T76 Catheterization
T77 Colonoscopy
T78 Cryosurgery
T79 Discogram
T80 Electroconvulsive Therapy
T81 Endoscopy
T82 Esophageal Dilatations
T83 Injection/Immunization
T84 Laparoscopy
T85 Lasers, used in treatment
T86 Myelography

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

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

State: _____ Year: _____

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

_____

_____

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

State: _____ Year: _____

Circumstances: _____

_____

_____

DISCIPLINARY CHARGES OR ACTION (QUESTION 4) - ATTACH DOCUMENTS

Name of Organization Involved: _____ Date: _____

Duration: _____

Action Taken (circle all that apply):

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial or right or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other Specify: _____

Circumstances: _____

_____

_____

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

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

_____

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

DENIAL OF EXAMINATION PRIVILEGES (QUESTION 6) ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances under which examination privileges denied:

_____

_____

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

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

_____

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

Institution Involved: _____
Location: _____ Date: _____

Circumstances: _____

_____

_____

_____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

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

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

_____

TO RESPOND TO QUESTION 12 SEE PAGE ONE OF THIS FORM

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

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

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____

_____

_____

_____

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

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

_____

_____

_____

_____

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

Court: _____

City and State: _____

Charge: _____

Date: _____

Description: _____

_____

_____

_____

_____

Status: _____

_____

Conviction?: _____ Date: _____

Plea?: _____ Date: _____

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

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

Treating Organization: _____

Address: _____

_____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dates of Illness or Dependency: _____ to _____

Dates of Treatment: _____ to _____

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

Telephone: (_____) _____

_____

Contact Person at Program: _____

Edd Gilbert Lyon MD
140 Hospital Drive
Bennington, VT 05201

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

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/00 to 11/30/02.
TWO YEAR RENEWAL FEE: $350.00
Enclose a check in the amount of $350.00 made payable to the Vermont Board of Medical Practice.
Physicians 80 years of age or older or on full-time active military duty (verification required) are exempt from payment of a renewal fee; however, the physician license renewal application must be completed and submitted. LATE FEE: Applications post-marked or received after 11/30/00 are assessed a $25.00 late fee.

042-0006255

Edd Gilbert Lyon MD
140 Hospital Drive
Bennington, VT 05201

****

IMPORTANT:

- Please print legibly or type your answers.
- Answer all questions completely; it is not adequate to state that the Board already has the information.
- Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of 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 (Last) EDD (First) GILBERT (Middle) _____ (Former)

Vermont license number: 042 0006255 Other name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal _____

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

MAILING ADDRESS: 140 HOSPITAL DRIVE (Street)

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

OFFICE ADDRESS: SAME (Street)

_____ (City) _____ (State) _____ (Zip Code) _____ (Telephone)

HOME ADDRESS: [redacted] (Street)

[redacted] (City) (State) (Zip Code) (Telephone)

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

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

SPECIALTY

Specialty: FAMILY PRACTICE

Subspecialty: _____

American Specialty Board Certified: X Yes ___ No

Specialty: FAMILY PRACTICE Year Certified: 1978

If applicable, year recertified: 1996

PRACTICE

Do you have hospital privileges? X Yes ___ No

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

Name	Address	Dates/From-To	Specialty/Subspecialty
SOUTHWESTERN VT. MED. CENTER	HOSPITAL DR. BENNINGTON, VT. 05201	8/78 - PRESENT	FAMILY PRACTICE

LICENSE IN OTHER JURISDICTIONS

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

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

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

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

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

DURING THE PAST TWO YEARS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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. [redacted]

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

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

2. You must check one of the two statements below regarding taxes:

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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.)

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant Edd Lyon Date 11/6/00

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: EDD LYON MD

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: ~~MAMMA~~ PHICO

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: T 6 1 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.

1) Healthy
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 ~~a~~ member of partnership 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	02 Labor/Delivery	03 Laboratory/X-Ray/Testing	04 Operating Room
05 Outpatient	06 Patient Room	07 Hospital-Other	~~08 Hospital-Unknown~~
09 HMO	10 Clinic	11 Nursing Home	(12 Physician's Office)
13 Walk-In Center	14 Other ____	15 Unknown	

Question 12 continued on next page

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

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

Your Role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

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

Name: Paul, Frank & Collins

Firm: David Spielman

Address: P.O. Box 1307

City, State, Zip: Burlington, VT. 05402-1307

Telephone Number: (802) 658-2311

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: Settlement Award: _____

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

If your case was settled, indicate the following:

Settlement amount paid on your behalf: $11,000

Total settlement amount: _____

Date of Settlement: (Month, Day, Year) 8/22/00

_____ 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:

Case settled before it went to court by agreement among carrier and plaintiff.

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

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

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

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

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

Improper Treatment: Anesthesia Related
T07 Failure to obtain informed consent/exceeding consent obtained
T08 Failure to take adequate patient history
T09 Failure to monitor
T10 Failure to test equipment/improper use of equipment
T11 Improper intubation
T12 Improper positioning
T13 Wrong amount/type of anesthesia prescribed

T14 Allergic/adverse reaction
T15 Teeth damage
T16 Other Specify: _____

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

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

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

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

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

Improper Treatment: Specified Procedures
T73 Angiography
T74 Arteriography
T75 CAT scan

T76 Catheterization
T77 Colonoscopy
T78 Cryosurgery
T79 Discogram
T80 Electroconvulsive Therapy
T81 Endoscopy
T82 Esophageal Dilatations
T83 Injection/Immunization
T84 Laparoscopy
T85 Lasers, used in treatment
T86 Myelography

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

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

State: _____ Year: _____

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

_____

_____

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

State: _____ Year: _____

Circumstances: _____

_____

_____

DISCIPLINARY CHARGES OR ACTION (QUESTION 4) - ATTACH DOCUMENTS

Name of Organization Involved: _____ Date: _____

Duration: _____

Action Taken (circle all that apply):

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial or right or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other Specify: _____

Circumstances: _____

_____

_____

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

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

_____

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

DENIAL OF EXAMINATION PRIVILEGES (QUESTION 6) ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances under which examination privileges denied:

_____

_____

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

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

_____

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

Institution Involved: _____
Location: _____ Date: _____

Circumstances: _____

_____

_____

_____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

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

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

_____

TO RESPOND TO QUESTION 12 SEE PAGE ONE OF THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 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: _____

_____

_____

_____

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

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

_____

_____

_____

_____

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

Court: _____

City and State: _____

Charge: _____

Date: _____

Description: _____

_____

_____

_____

_____

Status: _____

_____

Conviction?: _____ Date: _____

Plea?: _____ Date: _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 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)

Treating Organization: _____

Address: _____

_____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dates of Illness or Dependency: _____ to _____

Dates of Treatment: _____ to _____

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

Telephone: (_____) _____

_____

Contact Person at Program: _____

malpractice info

3504

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

2002 PHYSICIAN'S LICENSE RENEWAL APPLICATION

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

Instructions

- *Please enclose a check in the amount of $350 payable to the Vermont Department of Health.*
  Note: Physicians 80 years of age or older or on full-time active military duty (verification required) are exempt from payment of a renewal fee; however, the physician license renewal application must be completed and submitted.
  LATE FEE: Applications post-marked or received after 11/30/02 are assessed a $25 late fee.
- *Please print legibly or type your answers. Please type or print in block letters, one letter (or digit) in each box.*
- *Answer all questions completely; it is not adequate to state that the Board already has the information.*
- *Use the enclosed Form A to provide explanations to "yes" answers in Parts II and III.*
- *Please be sure to write your name and license number on each attachment.*
- *Please be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.*
- *Make a copy of the completed form and all attachments for your own records.*
- *Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct.*
- *Please return the document in its entirety at your earliest convenience. Your current license expires on November 30, 2002.*

Part I - Identity Questions

Vermont Physician's License Number: 042-0006255

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

First name: EDD

Middle name: GILBERT

Last name: LYON

Extension:

RECEIVED
OCT 8 2002
VERMONT BOARD OF MEDICAL PRACTICE

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: MM DD YYYY [redacted]

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

Care of:

Street: 140 HOSPITAL DRIVE

Town/City: BENNINGTON

State: VT

Zip Code: 05201-

5. Your electronic addresses:

Home telephone (optional): ___ - ___ - ____ example: 802-555-1212

Work telephone: 802 - 447 - 1191 x

E-mail (optional):

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

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

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

If yes, complete the section below:

State	License Number	Date Issued (M M D D Y Y Y Y)	Status (Active, inactive, other)
OK		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** ☒ **No**

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

☐ **Yes** ☒ **No**

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

☐ **Yes** ☒ **No**

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

☐ **Yes** ☒ **No**

18. Are you presently a defendant in a criminal proceeding?

☐ **Yes** ☒ **No**

Part III - Confidential Section

Part III is exempt from public disclosure

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

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

[redacted]

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

[redacted]

MEDICAL QUESTIONS

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

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

[redacted]

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

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

[redacted]

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

23. Are [redacted] 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:

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

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

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

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

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

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

Part IV - Statutory Profile Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Revocation/Involuntary Restrictions

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

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

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

B. Other Restrictions

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

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

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

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

A. Judgments

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

Date M M D D Y Y Y Y	Court	State	Nature of Case	Amount Assessed Against You
1998	BENNINGTON SUPERIOR COURT	VT	☐ Judgment ☒ Arbitration	$11,000 paid by carrier for entire practice – I was not primary defendant.
			☐ Judgment ☐ Arbitration	
			☐ Judgment ☐ Arbitration	

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

I have no papers as this was settled out of court.

B. Settlements

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

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

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

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

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

School	City	State	Year of Graduation
Universidad Autonoma De Guad.	Guadalajara, Mexico	MX	
Albany Medical College	Albany,	NY	1975

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

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

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

School/Institution	Specialty	City	State	Year of Graduation
UNIV. OF OKLA.	FAMILY PRACTICE	TULSA	OK	1977

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		☒ yes ☐ no	Am. Board of F.P.	1978	1997
		☐ yes ☐ no			
		☐ yes ☐ no			

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

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

M	M	Y	Y	Y	Y
0	8	1	9	7	8

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

List all hospitals where you currently have hospital staff privileges:

Name	City	State		Year Started			
SOUTHWESTERN VT. MED. CENTER	BENNINGTON	V	T	1	9	7	8

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

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

A. Appointments

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

School	City	State		Nature of Appointment	From (year)	To (year)
UNIV. OF VERMONT	BURLINGTON	V	T	ASSOCIATE PROFESSOR	1990	Present

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

B. Teaching

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

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

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

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

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

Title	Publication	Year

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

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

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

Activities or Awards

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

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

What is the location of your primary practice setting?

Town or City: BENNINGTON

State: VT

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

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

☐ **Yes** ☒ **No**

If yes, please describe here the translating services available:

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

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

A. Medicaid participation

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

B. New Medicaid Patients

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

Part V - Clinical Practice Questions

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

- ☒ Active in clinical practice (in direct patient care) in Vermont
- ☐ Active in clinical practice (in direct patient care) outside Vermont
- ☐ Administration
- ☒ Teaching
- ☐ Research
- ☐ Not currently in active practice

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

BEFORE YOU CONTINUE:

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

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

M M	Y Y Y Y
0 8	1 9 7 8

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

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

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

Site 1: BENNINGTON

Site 2: RUTLAND

Site 3:

Site 4:

Question	Site 1	Site 2	Site 3	Site 4
B. Number of weeks per year that you spend providing direct patient care at this site: (Full-time is considered to be 48 weeks / year)	4 8	1 0		

Question	Site 1	Site 2	Site 3	Site 4
C. Chose the one description that best fits the practice setting (of each site). (If you provide hospital care to patients who originate from your office or clinic, chose only the setting from which they originate.)				
Community-based practice including associated hospital care (e.g., solo or group office sites, community health center)	☒	☐	☐	☐
Hospital-based practice (e.g., emergency rooms, in-patient services, out-patient services, laboratory, etc.)	☐	☐	☐	☐
School or college health center	☐	☐	☐	☐
Business or work site	☐	☐	☐	☐
Extended care/nursing home	☐	☐	☐	☐
Other: Planned Parenthood	☐	☒	☐	☐

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

	Site 1	Site 2	Site 3	Site 4
Specialty Code	0601	0601		
(Specialty name, if code unknown)				
Hours per week	50	03		
Secondary Specialty, if any				
Hours per week in secondary specialty				
Tertiary Specialty, if any				
Hours per week in tertiary specialty				

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

Part VI - Signature

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

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

Date: 10/2/02

Edd Lyn MD

Applicant's Signature

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

✓ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

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

Regarding Taxes

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

2. You must check one of the two statements below regarding taxes:

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant Edd Tyler Date 10/2/02

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

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

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

_____

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

State_____ Year_____

Circumstances_____

_____

Disciplinary charges or action (Question 12) - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

Denial of examination privileges (Question 13) - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

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

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

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

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

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

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

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

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

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

Treating organization _____

Address _____ Telephone _____

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

_____

_____

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

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

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101 Allergy and Immunology
0102 Clinical & Laboratory Immunology

0201 Anesthesiology
0202 Critical Care Medicine
0203 Pain Management

0301 Colon & Rectal Surgery

0401 Dermatology
0402 Dermatopathology
0403 Clinical & Laboratory Dermatology
0404 Dermatological Immunology

0501 Emergency Medicine
0502 Medical Toxicology
0503 Pediatric Emergency Medicine
0504 Sports Medicine

0601 Family Practice
0602 Geriatric Medicine
0603 Sports Medicine

0701 Internal Medicine
0702 Adolescent Medicine
0703 Cardiac Electrophysiology
0704 Cardiovascular Disease
0705 Critical Care Medicine
0706 Clinical & Lab Immunology
0707 Endocrinology Diabetes & Metabolism
0708 Gastroenterology
0709 Geriatric Medicine
0710 Hematology
0711 Infectious Disease
0712 Medical Oncology
0713 Nephrology
0714 Pulmonary Disease
0715 Rheumatology
0716 Sports Medicine

0801 Medical Genetics
0802 Clinical Biochemical Genetics
0803 Clinical Biochemical/Molecular Genetics
0804 Clinical Cytogenetics
0805 Clinical Genetics (Md)
0806 Clinical Molecular Genetics

0901 Neurological Surgery
0902 Critical Care Medicine
1001 Nuclear Medicine

1101 Obstetrics & Gynecology
1102 Critical Care Medicine
1103 Gynecologic Oncology
1104 Maternal & Fetal Medicine
1105 Reproductive Endocrinology

1201 Ophthalmology

1301 Orthopaedic Surgery
1302 Hand Surgery

1401 Otolaryngology
1402 Otology/Neurotology
1403 Pediatric Otolaryngology

1501 Anatomic & Clinical Pathology
1502 Anatomic Pathology
1503 Clinical Pathology
1504 Blood Banking/Transfusion Medicine
1505 Chemical Pathology
1506 Cytopathology
1507 Dermatopathology
1508 Forensic Pathology
1509 Hematology
1510 Immunopathology
1511 Medical Microbiology
1512 Neuropathology
1513 Pediatric Pathology

1601 Pediatrics
1602 Adolescent Medicine
1603 Clinical & Laboratory Immunology
1604 Medical Toxicology
1605 Neonatal-Perinatal Medicine
1606 Pediatric Cardiology
1607 Pediatric Critical Care Medicine
1608 Pediatric Emergency Medicine
1609 Pediatric Endocrinology
1610 Pediatric Gastroenterology
1611 Pediatric Hematology-Oncology
1612 Pediatric Infectious Disease
1613 Pediatric Nephrology
1614 Pediatric Pulmonology
1615 Pediatric Rheumatology
1616 Pediatric Sports Medicine
1617 Children with Special Health Needs

1701 Physical Medicine & Rehabilitation

1801 Plastic Surgery
1802 Hand Surgery

1901 Preventive Medicine
1902 Aerospace Medicine
1903 Occupational Medicine
1904 Public Health & General Preventive
1905 Medical Toxicology
1906 Underseas Medicine

Psychiatry & Neurology
(Board Name - Not A Specialty)
2001 Psychiatry
2002 Neurology
2003 Neurology With Special Qualifications In Child Neurology
2004 Addiction Psychiatry
2005 Child & Adolescent Psychiatry
2006 Forensic Psychiatry
2007 Geriatric Psychiatry
2008 Clinical Neurophysiology

2101 Radiology
2102 Diagnostic Radiology
2103 Radiation Oncology
2104 Radiological Physics
2105 Nuclear Radiology
2106 Pediatric Radiology
2107 Vascular & Interventional Radiology

2201 Surgery
2202 Surgery Of The Hand
2203 Pediatric Surgery
2204 Surgical Critical Care
2205 General Vascular Surgery

2301 Thoracic Surgery

2401 Urology

4001 Abdominal Surgery
4002 Acupuncture
4003 Addiction Medicine
4004 Adult Reconstructive Orthopedics
4005 Allergy

4006 Cardiovascular Surgery
4007 Clinical Pharmacology
4008 Diabetes

4009 Facial Plastic Surgery

4010 General Practice

4011 Gynecology
4012 Head & Neck Surgery
4013 Hepatology
4014 Homeopathic Medicine
4015 Immunology

4016 Legal Medicine
4017 Musculoskeletal Oncology
4018 Neuroradiology
4019 Nutrition
4020 Obstetrics

4021 Oral & Maxillofacial Surgery
4022 Orthopedic Surgery Of The Spine
4023 Orthopedic Trauma
4024 Pain Medicine
4025 Pediatric Allergy

4026 Pediatric Ophthalmology
4027 Pediatric Orthopedics
4028 Pediatric Surgery (Neurology)
4029 Pediatric Urology
4030 Psychoanalysis

4031 Radioisotopic Pathology
4032 Sports Medicine (Orthopedic Surgery)
4033 Traumatic Surgery
4034 Sleep Medicine

9001 Rotating Internship (Residency)
9999 Other - Please Specify

STATE OF VERMONT
BENNINGTON COUNTY, SS

BENNINGTON SUPERIOR COURT
CIVIL ACTION
DOCKET NO.

RACHEL L. MIDDLESTEADT
Plaintiff

v.

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:

1. 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.
2. 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.

7. 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.

8. 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.

10. 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.

11. 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.

14. 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.

F) Defendants failed to warn Plaintiff of the dangers in a missed or, incomplete abortion, specifically that if the products conception are retained for more than about six weeks, the 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.

I) 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 life-log 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.

24 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.

26. 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;

D) 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;

G) Negligently, carelessly and improperly failed to provide and / or utilize 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;

I) 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.

27. That as a direct and proximate result of one or more of the foregoing 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 / 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.

28. 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.

31. 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

32. 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.

33. 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.

34. During the procedure at the Southern Vermont Women's Health 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.

37. 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.

38. 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:

1) 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;
4) 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

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 MD

Edd Lyon, MD

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, item _____
- ☐ Page 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

29A was filled out and it was incorrectly filled out

See attached Letter

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

B. Other Restrictions

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

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

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

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

A. Judgments

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

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

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

B. Settlements

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

Date M M	D D	Y Y Y Y	Court	State		Amount of Settlement Against You
0 9	2 1	2 0 0 0	Bennington Superior Court.	V	T	$11,000.00

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

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

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

School	City	State		Year of Graduation			
Universidad Autonoma De Guad.	Guadalajara, Mexico						
Albany Medical College	Albany,	N	Y	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	State		Year of Graduation			
UNIV. OF OKLA.	FAMILY PRACTICE	TULSA	O	K	1	9	7	9

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
0	6	0	1		☒ yes ☐ no	Am. Board of F.P.	1978	1997
					☐ yes ☐ no			
					☐ yes ☐ no			

Edd Lyon, MD
140 Hospital Drive
Bennington VT 05201

Vermont Department of Health
Board of Medical Practice

Agency of Human Services

November 25, 2002

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- ☐ 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

29A was filled out and it was incorrectly filled out

See attached Letter

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

Edd Lyon, MD
140 Hospital Drive
Bennington VT 05201

Vermont Department of Health
Board of Medical Practice

Agency of Human Services

November 25, 2002

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- ☑ Page 7, item documentation for 29
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- ☐ 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

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

2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

1. **Your legal name:** LYON, EDD GILBERT

Last Name | First Name | Middle Name | Suffix

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

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

Last Name | First Name | Middle Name: | Suffix

b. Indicate your name, as it should appear on your license:
LYON EDD GILBERT MD
Last Name | First Name | Middle Name: | Suffix

2. **Your Date of Birth:** [redacted]
Month / Day / Year

3. **Home Address:**
[redacted]
(Street)
[redacted]
(City) (State) (Zip)

4. **Work Address:**
140 HOSPITAL DRIVE
BENNINGTON, VT 05201
(Street)
(City) (State) (Zip)

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

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

7. Work Telephone Number with Area Code: (802) 447 - 1191

8. E-mail address: [redacted]

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

PART II

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

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

None reported

State	License Number	Type of License	Date Issued	Status (Active or Inactive)
OKLA.		MD	1975	Inactive

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

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

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

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

14. **Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?**
☐ yes ☒ no

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

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

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

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

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

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

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

participated or do participate in a monitoring program.

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

[redacted]

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

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

[redacted]

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

26. **Criminal Convictions** [26 VSA § 1368(a)(1)] X Check here if none E-1 - 9/16/04

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

None reported

(Conviction Date) (Court) (City/State) (Crime 9/16/04

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] X Check here if none E-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 not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

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

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

(Date) (Final Disposition - Summary)

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

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

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

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

A. **Revocation/Involuntary Restrictions** 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

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

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

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

(Date) (Hospital) (State)

(Nature of Action) (Action)

In lieu In settlement

(Reason for Action)

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

A. Judgments ☒ Check here if none

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

Judgement Arbitration
None

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

B. Settlements ☐ Check here if none

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

22 Aug 2000 NC $11,000.00

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

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

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

ALBANY MEDICAL COLLEGE, NY

1975

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

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

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

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

University of Oklahoma College of Medicine-Tulsa ,OK

Family Practice

1978

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

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

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

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

Family Practice
American Board of Family Practice
1978, 1997

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		☒ yes ☐ no	Am. Board of F.P.	1978	2003
		☐ yes ☐ no			

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

Month and year you started practicing as a physician? 8//1978

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

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

Southwestern Med. Ctr.

VT

(1978-)

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

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

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

A. Appointments ☐ Check here if none

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

University of Vermont

Burlington, VT

Associate Professor

1990 - present

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

B. Teaching ☒ Check here if none

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

None reported

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

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

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

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

None reported

(Title) (Publication) (Year)

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

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

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

None reported

(Activities or Awards)

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

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

Town or City State

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

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

If yes, please describe here the translating services available:

None

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

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

A. Medicaid participation

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

B. New Medicaid Patients

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

Part V

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

Date: 9/9/04 Edd Lyon 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

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

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

_____

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

State_____ Year_____

Circumstances_____

_____

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

(Question 15) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

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

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

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

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

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

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

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

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

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

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

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

Treating organization _____

Address _____Telephone _____

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

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim

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

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

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

Your role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

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

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

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

Regarding Taxes

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

2. You must check one of the two statements below regarding taxes:

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant Edd Lyon MD Date 9/7/04

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.

Indemnification: I, Rachel L. Middlesteadt, further promise and bind myself jointly 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.

Confidentiality: 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 22 day of August, two thousand.

Rachel L. Middlesteadt

Rachel L. Middlesteadt

STATE OF NORTH CAROLINA
COUNTY OF WAKE, SS.

On this 22ND day of AUGUST, 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, [signature]
Notary Public

Clients:214821_v1: 3157-00114

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

2006 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0006255

1. **Your legal name:**

   Edd Gilbert Lyon

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

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

Last Name	First Name	Middle Name:	Suffix

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

Lyon	Edd	Gilbert	MD
Last Name	First Name	Middle Name:	Suffix

RECEIVED
SEP 28 2006
VT BOARD OF MEDICAL PRACTICE

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

3. **Home Address and email address:**

   140 Hospital Dr., Ste. 108
   Bennington, VT 05201
   [redacted]

   [redacted]

4. **Work Address:**

   140 Hospital Dr., Ste. 108
   Bennington, VT 05201
   [redacted]

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

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

7. **Work Telephone Number with Area Code:** (802) 447-1191

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

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

PART II

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

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

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

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, e.g. conditioned, restricted, limited)
OK 1975		Medical		inactive

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

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

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

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

14. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
☐ yes ☒ no

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

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

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

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

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

20. Are you presently or have you ever been a defendant in a criminal proceeding?
☐ yes ☒ no

PART III

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

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

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

[redacted]

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

[redacted]

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

[redacted]

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

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

[redacted]

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

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

[redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

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

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

None reported

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

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

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

None reported

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

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

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

None reported

(Date) (Final Disposition - Summary)

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

☒ Check here if none

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

None reported

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

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

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

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

None reported

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

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

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

None reported

(Date) (Hospital) (State)

(Nature of Action) (Action) ☐ In lieu ☐ In settlement

(Reason for Action)

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

A. **Judgments** ☒ Check here if none

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

None reported

☐ Judgement ☐ Arbitration

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

B. Settlements ☐ Check here if none

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

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. Settled out of court by malpractice carrier for $9,000

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

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

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

ALBANY MEDICAL COLLEGE, NY

1975

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

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

University of Oklahoma College of Medicine-Tulsa ,OK

Family Practice

1978

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

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

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

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

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

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		☒ yes ☐ no	A.B.F.P.	1978	2003
		☐ yes ☐ no			

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

Month and year you started practicing as a physician? **8//1978**

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

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

Southwestern Med. Ctr.
VT
(1978-)

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

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

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

A. Appointments ☐ Check here if none

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

None reported

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

B. Teaching ☐ Check here if none

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

None reported

University of Vt School of Med. Burlington, Vt Clinical instructor 1998-present
(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

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

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

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

(Title) (Publication) (Year)

(Title) (Publication) (Year)

(Title) (Publication) (Year)

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

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

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

None reported

(Activities or Awards)

(Activities or Awards)

(Activities or Awards)

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

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

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

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

If yes, please describe here the translating services available:

None

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

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

A. **Medicaid participation**

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

B. **New Medicaid Patients**

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

Part V

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

Date: 9/19/06 Edd Lyons

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

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

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

Regarding Taxes

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

2. You must check one of the two statements below regarding taxes:

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant 9/19/06 Date

PD 5000

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

RECEIVED
OCT 21 2008
Vermont Board of Medical Practice

PART I

License Number: 042-0006255

1. **Your legal name:**

   Edd Gilbert Lyon

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

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

   Last Name | First Name | Middle Name: | Suffix

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

   Last Name | First Name | Middle Name: | Suffix

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

3. **Home Address and email address:**

   ~~140 Hospital Dr., Ste. 108~~ [redacted]
   Bennington, VT 05201
   [redacted]

4. **Work Address:**
   140 Hospital Dr., Ste. 108
   Bennington, VT 05201
   [redacted]

5. **Please check your preferred mailing address: ____ Home ✓ Work**
   NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** ([redacted]

7. **Work Telephone Number with Area Code:** (802) 447-1191

8. **E-mail address (if not appearing in #3):**

Please check here if the Department of Health may use this e-mail address to send you public health information.
X yes ☐ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
OK	1975	MD		Inactive

If necessary, please use an additional sheet and check this box: .....☐

11. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

ALBANY MEDICAL COLLEGE, NY
1975

12. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

University of Oklahoma College of Medicine-Tulsa ,OK
Family Practice
1978

If necessary, please use an additional sheet and check this box: .....☐

13. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Family Practice
American Board of Family Practice
1978, 1997, 2003

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☒ yes ☐ no		1978	2003
		☐ yes ☐ no			

14. Years of Practice [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? 8//1978

15. Hospital Privileges [26 VSA § 1368(a)(11)] ☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

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 ☒ no

18. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes ☒ no

19. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes ☒ no

20. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□ yes ☒ no

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?

□ yes ☒ no

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□ yes ☒ no

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes ☒ no

24. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes ☒ no

25. Do you currently or have you ever prescribed any prescription medication over the internet?

□ yes ☒ no

26. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?

[redacted]

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

29. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

30. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

31. Are you currently engaged in the illegal use of controlled substances?

[redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthvermont.gov.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

33. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

34. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

35. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]
☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

36. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

B. **Other Restrictions** ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

37. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments** ☒ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

B. **Settlements** ☐ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

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

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

39. **Publications**: [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. **Activities** [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

41. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting?

BENNINGTON, VT

42. **Translating Services** [26 VSA § 1368(a)(16)] ☒ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location?

If yes, please describe here the translating services available:

None

43. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes ☐ no

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes ☐ no

Part V

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 9/10/08

Edd Lyon MD

Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☐ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☐ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☐ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 18) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 19) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

(Question 20) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 23) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 24) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

(Question 25) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 29-30) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Your role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

_____

_____

_____

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

☒ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

☒ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10, 000.00 fine or both.)

or

☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant Edward Lyon Date 9/10/08

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Date: 9/10/08

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.

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

RECEIVED
OCT - 1 2010
Vermont Board of Medical Practice

License Number: 042-0006255

1. **Your legal name:**

   Edd Gilbert Lyon

   a. Have you ever legally changed your name? ___Yes ✓ No

   If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

   Last Name First Name Middle Name: Suffix

   b. Indicate your name, as it should appear on your license:

   Last Name First Name Middle Name: Suffix

2. **Your Date of Birth:** [redacted]

3. **Mailing Address and email address:**

   140 Hospital Dr., Ste. 108
   Bennington, VT 05201
   [redacted]

4. **Work Address:**
   140 Hospital Dr., Ste. 108
   Bennington, VT 05201
   [redacted]

5. **Please check your preferred mailing address:** ___ **Home** ✓ **Work**
   NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** (_____)_____

7. **Work Telephone Number with Area Code:** (_____)_____

8. **E-mail address (if not appearing in #3):**

_____

Please check here if the Department of Health may use this e-mail address to send you public health information.

□ yes □ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? X yes □ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
X yes □ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
OK	1975			

If necessary, please use an additional sheet and check this box: .....□

11. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

ALBANY MEDICAL COLLEGE, NY
1975

12. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

University of Oklahoma College of Medicine-Tulsa ,OK
Family Practice
1978

If necessary, please use an additional sheet and check this box: .....□

13. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Family Practice
American Board of Family Practice
1978, 1997, 2003

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0601		X yes □ no	ABFP	1978	
		□ yes □ no			

14. Years of Practice [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? Aug-78

15. Hospital Privileges [26 VSA § 1368(a)(11)] □ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

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 ☒ no

18. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes ☒ no

19. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes ☒ no

20. Have you ever been denied the privilege of taking an examination before any state medical examining board?

□ yes ☒ no

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months?

□ yes ☒ no

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?

□ yes ☒ no

23. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes ☒ no

24. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes ☒ no

25. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.

□ yes ☒ no

26. Are you presently or have you ever been a defendant in a criminal proceeding?

□ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?

[redacted]

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

29. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

30. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your

use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

31. Are you currently engaged in the illegal use of controlled substances? [redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthvermont.gov.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☑ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

33. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☑ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

34. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☑ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

35. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]
☑ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

36. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

ΣX
10/6/10

A. **Revocation/Involuntary Restrictions** ☑ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

B. **Other Restrictions** ☑ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

37. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments** ☑ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

B. **Settlements** ☑ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

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

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

39. Publications: [26 VSA § 1368(a)(13)] ☑ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. Activities [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

41. Practice Setting [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting?

BENNINGTON, VT

42. Translating Services [26 VSA § 1368(a)(16)] ☐ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location?

If yes, please describe here the translating services available:

~~None~~ YES - Personal Interpreter Service with Language Line Services

43. Medicaid/New Patients [26 VSA § 1368(a)(17)]

A. Medicaid participation

Do you participate in the Medicaid program? ☒ yes ☐ no

B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☐ yes ☒ no

Part V

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 9/1/10

Edd Lyon MD

Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☐ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☐ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☐ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

_____

(Question 18) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 19) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)_____

Circumstances_____

_____

_____

(Question 20) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances_____

_____

(Question 23) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances_____

_____

(Question 24) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

(Question 25) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____ _____

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 29-30) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Your role (circle one):

01 Anesthesiologist	11 PGY 4
02 Primary Care Physician	12 PGY 5
03 Referring Physician	13 PGY 6
04 Attending Physician	14 PGY 7
05 Consultant Specialist	15 Workmen's Compensation Evaluator
06 Surgeon	16 Court Psychiatrist
07 Fellow	17 On-Call Physician
08 PGY 1	18 Group Practitioner/Partner
09 PGY 2	19 Other: Specify _____
10 PGY 3	20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year)
_____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

_____

_____

_____

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to http://www.atg.state.vt.us/ and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

* *

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 045470-0070.**

I consent:

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I _____ **(print name)** hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
PO Box 70
Burlington, VT 05402-0070

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Signature: Edd Lyon Date: 9/1/10

PLEASE NOTE:

In accordance with 4 V.S.A. §1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

☑ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

☑ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

☑ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10, 000.00 fine or both.)

or

☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant Edd Lyon Date 9/1/10

VERMONT

Edd Lyon MD
140 Hospital Drive Suite 108
Bennington, VT 05201

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: October 1, 2010

RECEIVED
OCT - 6 2010
Vermont Board of Medical Practice

Dear Physician:

Your 2010 Physician's License Renewal application has been received by this office and cannot be processed until the following information is received.

- ☐ $500 renewal fee
- ☐ $25 late fee

Application

Part I

- ☐ Item 1
- ☐ Item 2
- ☐ Item 3
- ☐ Item 4
- ☐ Item 5
- ☐ Item 6
- ☐ Item 7
- ☐ Item 8

Part II

- ☐ Item 9
- ☐ Item 10
- ☐ Item 11
- ☐ Item 12
- ☐ Item 13
- ☐ Item 14
- ☐ Item 15
- ☐ Item 16
- ☐ Item 17

Part III

- ☐ Item 18
- ☐ Item 19
- ☐ Item 20
- ☐ Item 21
- ☐ Item 22
- ☐ Item 23
- ☐ Item 24
- ☐ Item 25
- ☐ Item 26

Part IV

- ☐ Item 27
- ☐ Item 28
- ☐ Item 29
- ☐ Item 30
- ☐ Item 31

- ☐ Item 32
- ☐ Item 33
- ☐ Item 34

- ☐ Item 35
- ☐ Item 36A
- ☐ Item 36B
- ☐ Item 37A
- ☐ Item 37B
- ☐ Item 38A
- ☐ Item 38B
- ☐ Item 39
- ☐ Item 40
- ☐ Item 41
- ☐ Item 42
- ☐ Item 43A
- ☐ Item 43B

Part V

- ☐ Date
- ☐ Signature

Child Support, Taxes, Unemployment Compensation Statement

- ☐ Number 1 – check one of the two statements
- ☐ Number 2 – check one of the two statements
- ☐ Number 3 – check one of the three statements
- ☐ Sign, Date, SSN, DOB

Additional Forms

- ☐ Completed form A
- ☐ Statement of Good Standing

The page(s) that need(s) completion (if applicable) is/are attached. Please complete the necessary item(s), initial, date and return as soon as possible so that processing may be finalized. **The information cannot be faxed.**

Thank you.

Sincerely,
Medical Practice Board

Enclosures

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:
[redacted]

7. Enter your MAILING ADDRESS information:

Attention
Street [redacted]
City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States
E-mail Address
Telephone [redacted] **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 **Country**: United States **School Type**: Medical School **Degree**:	05/01/1975

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. 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

15. **Years of Practice**
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

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

17. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
No

18. State:

19. Year:

20. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

21. Denied certificate to practice medicine or any other healing art - Upload documents

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
No

23. State:

24. Year:

25. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:

26. Please upload any documents you have that are relevant to this matter.

27. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
No

28. State:

29. Year:

30. Circumstances:

31. Please upload any documents you have that are relevant to this matter.

32. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
No

33. Name of organization involved:

34. Date:

35. Duration:

36. Action Taken (add all that apply):

37. Circumstances:

38. Please upload any documents you have that are relevant to this matter.

39. Have you ever been denied the privilege of taking an examination before any state medical examining board?
No

40. State:

41. Year:

42. Circumstances under which examination privileges denied:

43. Please upload any documents you have that are relevant to this matter.

44. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
No

45. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:

46. Discontinued Education, Training, or Clinical Practice - Upload documents:

47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?
No

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances:

52. Please upload any documents you have that are relevant to this matter.

53. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
No

54. Institution involved:

55. Location:

56. Year:

57. Circumstances:

58. Please upload any documents you have that are relevant to this matter.

59. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
No

60. Name of organization involved:

61. Type of restriction:

62. Date:

63. Circumstances of restriction

64. Please upload any documents you have that are relevant to this matter.

65. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice.
No

66. Please provide a general description of your practice of internet prescribing:

67. Are you presently, or have you ever been, a defendant in a criminal proceeding?
No

68. Court:

69. City and state:

70. Charge:

71. Description:

72. Status:

73. Date:

Renewal Part III

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained.

74. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?

75. Licensing or certification board:

76. Date:

77. Location of Licensing Board:

78. Circumstances:

79. Please upload any documents you have that are relevant to this matter.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled

Substances Act or other provisions of federal law.

80. Do you have a medical condition that in any way impairs or potentially impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

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:

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

Renewal Part IV

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can.

99. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets)? For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction.

No

100. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description

101. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Have there been any charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction?

No

102. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continue without finding by a court of competent jurisdiction.

Date of Charges	Court	City	State	Description of Charges

103. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have there been any formal charges served, findings, conclusions, and/or orders of the Board of Medical Practice (including stipluations), and/or final disposition of such matters by the courts, if appealed?

No

104. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipluations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary

105. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have there been any formal charges served against you by licensing or certification authorities of other states?

No

106. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**

Date of Disposition	Licensing Authority	City	State	Description of Disposition

Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

107. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?

No

108.

A. Revocation/Involuntary Restrictions
Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please upload copies of papers fully documenting these matters.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction

109. Have your hospital privileges ever been restricted, or have you ever resigned or not renewed your medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital?
No

110.
B. Other Restrictions
Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please upload copies of papers fully documenting these matters.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement

111. **Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]** Have you ever been involved in a Malpractice Liability Claim? Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.
Yes

112.
A. Judgments
Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Date of Judgment

113.
B. Settlements Please provide a description of all settlements of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

Date Of Settlement
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	Nature of Appointment	Year Started	Year Ended
University of Vermont College of Medicine	Burlington	Vermont	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

116. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date

117. Activities [See 26 VSA § 1368(a)(14)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

Activity or Award

118. Provide the following information for each practice location. Be sure to indicate which is to be your primary practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
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 must select one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support

order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

122. You must select one of the two statements below regarding taxes:

I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both.)

The disclosure of your social security number is manditory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

123. Social Security Number:

[redacted]

124. Date of Birth:

[redacted]

125. I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Yes

126. Date:

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

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

Malpractice Claim Documentation – 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:

- 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:
- 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:
[redacted]

7. Please provide your preferred email address for receiving important correspondence from this medical board
[redacted]

8. Enter your MAILING ADDRESS information:

Attention
Street [redacted]
City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States
E-mail Address
Telephone [redacted] **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?
No

12. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status

13. 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 **Country**: United States **School Type**: Medical School **Degree**:	05/01/1975

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?
1978

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.
No

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.
No

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.
No

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 for 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:

1. The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

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

practice medicine in your field of practice with reasonable skill and safety?

[redacted]

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.

89. Please upload any documents you have that are relevant to this matter.

90. Are you currently engaged in the illegal use of controlled substances?

[redacted]

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.

92. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

93. Treating organization:

94. Address:

95. Telephone:

96. Type of diagnosis, condition or treatment - field of practice - use of chemical substances:

97. Dates of illness or dependency (from, to):

98. Dates of treatment (from, to):

99. Name of rehabilitation/professional assistance or monitoring program:

100. Address:

101. Telephone:

102. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

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. **Criminal Convictions** [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.

No

104. **Criminal Convictions continued** [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.)

No

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.)

No

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

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

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.

Date

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: Providing the following Appointments and Teaching information is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

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	State	Nature of Teaching	Year Started	Year Ended

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

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	State	Primary Practice	Languages	Accepts Medicaid?	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 must select one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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:
[redacted]

129. Date of Birth:
[redacted]

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.
C

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