Hayes, Tracy

From: Dion, Beverly [Beverly.Dion@ppnne.org]
Sent: Monday, October 03, 2011 1:26 PM
To: Hayes, Tracy
Subject: Address changes ~

Hello Tracy,

I'm writing to notify the Board of the following address changes for four of Planned Parenthood's providers:

Dr. Regan Theiler, license #: 042-0012264
As of 10/15/2011 relocating to:
128 Lakeside Ave
Suite 301
Burlington, VT 05401
448-9700 (PH)

[redacted]

Please confirm receipt of this email and let me know if you need any more information to make these changes.
Thank you,

Bev Dion

Credentialing Coordinator
Planned Parenthood of Northern New England
802.288.8432 (ph)
802.878.8001 (fax)

VERMONT

Department of Health
Board of Medical Practice
108 Cherry Street - PO Box 70
Burlington, VT 05402-0070
healthvermont.gov

[phone] 802-657-4220
[toll free] 800-745-7371
[fax] 802-657-4227

Agency of Human Services

July 22, 2011

Regan Theiler MD
[redacted]

Re: Vermont Medical Licensure - **042-0012264**

Dear Dr. Theiler:

Congratulations on receiving a license to practice medicine in Vermont. On July 20, 2011 the Vermont Board of Medical Practice granted you a Vermont medical license. Please note above. Enclosed please find your physician license and information relevant to practice in Vermont.

All medical licenses are renewed in November of every even year. You will receive a notification three months prior to the renewal date. Until that time, ***licensees have a continuing obligation to promptly notify the Board of any change or new information including, but not limited to, change of address, 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.***

If you have any questions or need additional information please do not hesitate to contact the Board.

Sincerely,

Karen LaFond
Licensing Administrator
Board of Medical Practice

State of Vermont
Board of Medical Practice

THIS IS TO CERTIFY

Regan Nell Theiler MD

a graduate of The University of Wisconsin, 2003

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

Patricia A. King MD PhD

Chair: Patricia A. King, MD, PhD

Margaret Funk Martin

Secretary: Margaret F. Martin
Burlington
Date: July 20, 2011
Received and duly recorded.
Vermont Department of Health

License Number 042-0012264

Medical Doctor Application Checklist

For Office Use Only

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

Name of Applicant: Regan Nell Theiler

Mailing Address: [redacted]

Public Address: Planned Parenthood of NE 183 Talcott Rd Williston, VT 05495

Telephone: 802-288-8416

Date Application Received: 10/14/11

1) X FEE of $625

2) X COMPLETED APPLICATION for License to Practice Medicine in Vermont.

- X Photograph Applicant's signature required on photograph.
- X Tax & Child Support Statement Applicant's signature required [redacted]
- X Statement of Good Standing
- X Release Form Applicant's signature required.

*3) X BIRTH CERTIFICATE [redacted] be certified Copy
Date of Birth: [redacted]

*4) X COPY OF MEDICAL SCHOOL DIPLOMA

*5) X MEDICAL EDUCATION DIRECT VERIFICATION
Univ of Wisconsin Madison Date: 05- -2003

6) X MEDICAL LICENSURE CERTIFICATE - Direct Verification
X TX
X GA

*7) X EXAMINATION SCORES: Direct Verification of Examination Scores:
X USMLE** ____ FLEX ____ National Boards ____ State Exam ____ LMC

8) X AMERICAN SPECIALTY BOARD CERTIFICATE
OB/GYN (BC)

*9) X POSTGRADUATE TRAINING DIRECT VERIFICATION

Emory Univ DATES 03-07 ACGME _____

_____ DATES _____ ACGME _____

_____ DATES _____ ACGME _____

_____ DATES _____ ACGME _____

_____ DATES _____ ACGME _____

10) X Three (3) COMPLETED REFERENCE FORMS mailed directly to the Board.

X #1 Gary Hankins

X #2 Trish Muir

X #3 Russell Snyder

11) X American Medical Association Profile Form.

☒ Verify information provided on application

*12) N/A ECFMG Certificate, if International Graduate

☐ Passed/Approved

13) X National Practitioners Data Bank self-query: Applicant sends the original, unaltered response to the Board.

☐ Has applicant included everything on the application

14) N/A FORM A if applicant answered yes—Refer to licensing Committee

15) X CV/Resume

16) ___ FEDERATION CHECK

*Note: FCVS Acceptance- The Board accepts certain documents (see * above) verified by the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). For more information please call 1-888-ASK-FCVS.*

Application for Physician Licensure

1. Name: Indicate your full legal name. 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. Full Name (use no initials)

Last Name Theiler

First Name Regan

Middle Name Nell

Suffix

Maiden Name

M.D. ☒ D.O. ☐

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

Practice Address
☒ Public Access
☒ Mailing

Street Planned Parenthood Northern New England
183 Talcott Rd
City Williston State/Province VT ZIP Code 05495
Telephone 802/288-8416 Fax
E-mail address [redacted]
Alternate Phone (e.g. pager or cell phone) [redacted]

Home Address
☐ Public Access
☐ Mailing

Street [redacted]
City [redacted]
Telephone [redacted] Fax
E-mail address [redacted]
Alternate Phone (e.g. pager or cell phone) [redacted]

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted] USA

Date of Birth (mm/dd/yyyy) | Birth City | Birth State/Province | Birth Country

F | [redacted] | 1609069558 | Are you a U.S. Citizen? ☒ Yes ☐ No

Gender | Social Security Number | NPI Number

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name University of Wisconsin Madison
   Address 1300 University Ave
   City Madison State/Province WI ZIP Code 53703
   Country USA
   Attendance Dates (From – To) 1996- 2003
   Graduation Date May 2003 Degree MD, PhD

2. School Name
   Address
   City State/Province ZIP Code
   Country
   Attendance Dates (From – To)
   Graduation Date Degree

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

1. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

2. Medical School Name _____

Address _____

City _____ State/Province _____ ZIP Code _____

Country _____

Attendance Dates (From – To) _____

Graduation Date _____ Degree _____

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name Emory University School of Medicine

Hospital Address 69 Jesse Hill Jr Drive

City Atlanta

State/Province GA

ZIP Code 30303

Country USA

PGY: (e.g., 1, 2, 3, etc.) 1-4 ☒ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☒ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other

Department/Specialty: Obstetrics + Gynecology

From: 7 / 2003 To: 6 / 2007 Successfully Completed? Yes ☒ No ☐ In Progress ☐

Month Year Month Year

2.Hospital Name

Hospital Address

City

State/Province

ZIP Code

Country

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other

Department/Specialty:

From: / To: / Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: Regan Theiler Date: 6/7/11

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ___/____ To: ___/____ Successfully Completed? Yes☐ No☐ In Progress☐

Month Year Month Year

4.Hospital Name_____

Hospital Address_____

City_____

State/Province_____

ZIP Code_____

Country_____

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other_____

Department/Specialty:_____

From: ___/____ To: ___/____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: Regan Theiler Date: 6/7/11

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
State Board Exam _____ State	_____	☐ P	☐ F	_____
FLEX Pre-1985	_____	☐ P	☐ F	_____
FLEX Component 1	_____	☐ P	☐ F	_____
FLEX Component 2	_____	☐ P	☐ F	_____
LMCC – Single	_____	☐ P	☐ F	_____
LMCC – Part I	_____	☐ P	☐ F	_____
LMCC – Part II	_____	☐ P	☐ F	_____
NBME Part I	_____	☐ P	☐ F	_____
NBME Part II	_____	☐ P	☐ F	_____
NBME Part III	_____	☐ P	☐ F	_____
SPEX	_____	☐ P	☐ F	_____
NBOME Part I	_____	☐ P	☐ F	_____
NBOME Part II	_____	☐ P	☐ F	_____
NBOME Part III	_____	☐ P	☐ F	_____
COMLEX-USA Level 1	_____	☐ P	☐ F	_____
COMLEX-USA Level 2, CE	_____	☐ P	☐ F	_____
COMLEX-USA Level 2, PE	_____	☐ P	☐ F	_____
COMLEX-USA Level 3	_____	☐ P	☐ F	_____
COMVEX	_____	☐ P	☐ F	_____
USMLE Step I	10|1998	☒ P	☐ F	1
USMLE Step II, CS	4|2003	☒ P	☐ F	1
USMLE Step II, CK	_____	☐ P	☐ F	_____
USMLE Step III	10|2004	☒ P	☐ F	1

Applicant Name: Regan Theiler Date: 6/7/11

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number _____ Issue Date _____ Valid Through Date _____

9. State/Province Professional Licensure whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

1. State/Province TX Type (MD, DO) MD License Number M6911 Status Active Issue Date 7/25/07
2. State/Province GA Type (MD, DO) MD License Number 000305 Status Inactive Issue Date 7/1/03
3. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
6. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
7. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
8. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
9. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____
10. State/Province _____ Type (MD, DO) _____ License Number _____ Status _____ Issue Date _____

Applicant Name: Regan Theiler Date: 6/7/11

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State/Province _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: July Year: 2007 To: Month: June Year: 2011	Practice/Employment Name University of Texas Medical Branch (or list non-working time as indicated above) Practice/Employment Address 301 University Blvd City Galveston State/Province TX ZIP Code 77555-0587 Country USA Position and Department Ob/Gyn % Clinical 25 % Administrative 75 Employment ☒ Staff Privileges ☐ Affiliation ☐ Other _____
2. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: Regan Theiler Date: 6/7/11

Dates: From/To	Practice/Employment
3. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ (or list non-working time as indicated above) Practice/Employment Address _____ City _____ State/Province _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: Regan Theile Date: 6/7/11

11. Malpractice Liability Claims Information (copy this form to report multiple claims)

Name of patient involved: _____

In which state did the action take place? _____ Case number (if applicable) _____

Which court? _____
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: _____

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out)
☐ Other _____

Amount of judgment or settlement $ _____ Amount paid on your behalf $ _____

Month and year of event precipitating claim: _____

Month and year of lawsuit: _____

Insurance carrier at time: _____

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: Theiler, Regan Date: 6/8/11

Addendum 1
Application for License to Practice Medicine in Vermont
Physician – Medical Doctor

1. Were you in active clinical practice in the past 12 months? X Yes _____ No

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

Month and year you started practicing as a physician (excluding residency/fellowship training)?

8/2007

3. Have you ever held a Vermont Limited Temporary License: _____ Yes X No

If yes, License Number: _____

4. Premedical Education

Please provide the names of premedical schools you attended and the dates of attendance.

Name and location of institution	Degree	From	To
DePaul University, Chicago IL	B.S.	1992	1996

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

5. Specialty Board Certification

Enter up to three specialty codes from the ***Specialty Codes List*** on Instructions page 3. 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)	Name of Board	Board Certified	Year Certified	Year Recertified
1	1	0	1		Ob/Gyn	☒ yes ☐ no	2009	
						☐ yes ☐ no		
						☐ yes ☐ no		

6. 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
UTMB	Galveston, TX	8/2007 - 6/2011	Ob/Gyn
Mainland Medical Center,	Texas City TX	9/2008 - 6/2011	Ob/Gyn

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 actions taken.

7. 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 or adjudged guilty by a court of competent jurisdiction. Please provide copies of papers fully documenting the convictions.

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

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

8. 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 finding by a court of competent jurisdiction. Please provide copies of papers fully documenting these matters.

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

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

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

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

(Date)	(Final Disposition – Summary)

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

10. 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. Please provide copies of papers fully documenting these matters.

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

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

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

A. Revocation/Involuntary Restrictions

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

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

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. Please provide copies of papers fully documenting these matters.

(Date) (Hospital) (State)

(Nature of Action) (Action) (Reason for Action)

☐ In Lieu ☐ In Settlement

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

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

Note: Answering #12 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)
UTMB	Galveston	TX	Assistant Professor	2007	2011
(School)	(City)	(State)	(Nature of Appointment)	From (year)	To (year)

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

B. Teaching

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

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year)	To (year)
UTMB	Galveston	TX	Ob/Gyn Residents	2007	2011
(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year)	To (year)

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

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

Note: Answering #13 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)

(Title) (Publication) (Year)

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

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

Note: Answering #14 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: .....☐

15. Interview

A. In which part of Vermont would you prefer to be interviewed? Northern-Burlington/St. Albans area, Southern-Rutland, Springfield, Central-Montpelier/Randolph, or using webcam (Please be specific)?

Northern

B. When are you scheduled to begin work in Vermont? 8/1/11

C. What is going to be the primary location of your practice setting? Planned Parenthood - Burlington

D. Provide a brief description of your anticipated practice: Medical director - all planned parenthood clinics in VT, NH, ME

E. What has been your physical residence (city, state) in the past ten years?

Galveston, TX 2007 - 2011, Atlanta, GA 2003 - 2007

Madison, WI ~~200~~ 1996 - 2003

Addendum 2

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

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

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

Withdrawal or denial of License – Attach documents

State_____Year_____

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

_____

_____

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

Voluntarily surrendered or resigned a license to practice medicine or any healing art – Attach documents

State_____Year_____

Circumstances_____

_____

_____

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__X__No

Disciplinary charges or action – Attach documents

Name of organization involved_____Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

_____

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

Denial of examination privileges – Attach documents

State_____

Circumstances under which examination privileges denied_____

_____

_____

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months? NOT including premedical education. ____Yes__X__No

If yes, Please explain:_____

_____

_____

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

Residency Training Program(s) not completed – discontinued education, training, practice – Attach documents

Residency Training Program(s)_____

Location of Programs_____Year_____

Circumstances_____

_____

_____

_____

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__X__No

Affecting Health Care Institution Staff Privileges, Employment or Appointment – Attach documents

Institution Involved_____

Location_____Year_____

Circumstances_____

_____

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__X__No

Privilege to prescribe controlled substances – Attach documents

Name of organization involved_____

Type of restriction_____Date_____

Circumstances of restriction_____

_____

_____

_____

_____

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

Court_____

City and State_____

Charge_____

Description_____

_____

_____

Status_____

_____

Date_____

26. 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__X__No

Please provide a general description of your practice of Internet prescribing_____

_____

_____

27. 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, and any pending malpractice cases; complete the below information and provide copies of papers fully documenting these matters.

☐ Judgment ☐ Arbitration

_____

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

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

B. Settlements

Please provide a description 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) (Court) (State) (Amount Assessed Against You)

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

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 Workman'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: _____

_____

_____

_____

Addendum 3

Return this form to the Board along with the completed application.
This information is confidential and is exempt from public disclosure.

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged? [redacted]

Criminal Investigation – Proceeding – Attach documents

Court_____

City and State_____

Charge_____

Description_____

Status_____

Date_____

29. 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]

Investigation by any other licensing board – Attach documents

Name of Licensing Board_____ Date_____

Location of Licensing Board_____

Circumstances_____

MEDICAL QUESTIONS

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

DEFINITIONS

In answering the 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.

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

In explaining a "Yes" answer, 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.

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

In explaining a "Yes" answer, 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.

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

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

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_____

Addendum 4

List of Three (3) References

List a total of three (3) references in the space below. The individuals listed must be a fully licensed physician attesting to your character and professional abilities. Return this sheet to the Board with your application.

Make three (3) copies of the attached Reference Form (Addendum 4A) and mail a copy to each individual listed below, along with a copy of the signed Affidavit and Authorization for Release of Information (UA Page 11). All completed Reference forms must be returned directly to the Board.

*NOTE: Program Director should be substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year.

Reference #1: Chief of Service (See Program Director Note* above):

Name: Gary D.V. Hankins
Address: 301 University Blvd
City, State, Zip: Galveston TX 77555-0587
Telephone: (409) 772-6803
How long and at what capacity has this individual known you? 4 yrs, Department Chair

Reference #2: Active physician staff member at the hospital where you have a current or recent appointment:

Name: Tristi Muir
Address: 301 University Blvd
City, State, Zip: Galveston TX 77555-0587
Telephone: (409) 772-2610
How long and at what capacity has this individual known you? 4 yrs, Colleague

Reference #3: Active physician staff member at the hospital where you have a current of recent appointment:

Name: Russell Snyder
Address: 301 University Blvd
City, State, Zip: Galveston TX 77555-0587
Telephone: (409) 772-5051
How long and at what capacity has this individual known you? 4 yrs, Division Director

NOTE: If you are unable to provide references from these individuals because you have never held hospital privileges, attach such an explanation to this form when you submit your application. Three other references from physicians you have worked with most recently will then be required.

Addendum 5

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:
   - [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 of 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 taxed would impose an unreasonable hardship (32 V.S.A. § 3113).

2. You must check on of the two statements below regarding taxes:
   - [X] I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000. fine or both).

   -OR-

   - [ ] I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application of 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 contribution:
   - [X] I hereby certify, under the pains of 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 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 of 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 Number: [redacted] Date of Birth: [redacted]

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

Statement of Applicant

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

Signature of Applicant: _____ Date: 6/7/11

Addendum 6

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

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

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

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

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

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

☐ I consent

_____ _____

Signature Date

_____ _____

Print Name Vermont License or Certification Number

Mailing Address (please print): _____

_____

_____

_____

Telephone Number: _____

The Vermont Statutes Online

Title 18: Health

Chapter 91: Prescription Drug Cost Containment

4631. Confidentiality of prescription information

§ 4631. Confidentiality of prescription information

(a) It is the intent of the general assembly to advance the state's interest in protecting the public health of Vermonters, protecting the privacy of prescribers and prescribing information, and to ensure costs are contained in the private health care sector, as well as for state purchasers of prescription drugs, through the promotion of less costly drugs and ensuring prescriber's receive unbiased information.

(b) As used in this section:

(1) "Electronic transmission intermediary" means an entity that provides the infrastructure that connects the computer systems or other electronic devices used by health care professionals, prescribers, pharmacies, health care facilities and pharmacy benefit managers, health insurers, third-party administrators, and agents and contractors of those persons in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment, or other prescription drug information.

(2) "Health care facility" shall have the same meaning as in section 9402 of this title.

(3) "Health care professional" shall have the same meaning as in section 9402 of this title.

(4) "Health insurer" shall have the same meaning as in section 9410 of this title.

(5) "Marketing" shall include advertising, promotion, or any activity that is intended to be used or is used to influence sales or the market share of a prescription drug, influence or evaluate the prescribing behavior of an individual health care professional to promote a prescription drug, market prescription drugs to patients, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.

(6) "Pharmacy" means any individual or entity licensed or registered under chapter 36 of Title 26.

(7) "Prescriber" means an individual allowed by law to prescribe and administer prescription drugs in the course of professional practice.

(8) "Promotion" or "promote" means any activity or product the intention of which is to advertise or publicize a prescription drug, including a brochure, media advertisement or announcement, poster, free sample, detailing visit, or personal appearance.

(9) "Regulated records" means information or documentation from a prescription dispensed in Vermont and written by a prescriber doing business in Vermont.

(c)(1) The department of health and the office of professional regulation, in consultation with the appropriate licensing boards, shall establish a prescriber data-sharing program to allow a prescriber to give consent for his or her identifying information to be used for the purposes described under subsection (d) of this section.

The department and office shall solicit the prescriber's consent on licensing applications or renewal forms and shall provide a prescriber a method for revoking his or her consent. The department and office may establish rules for this program.

(2) The department or office shall make available the list of prescribers who have consented to sharing their information. Entities who wish to use the information as provided for in this section shall review the list at minimum every six months.

(d) A health insurer, a self-insured employer, an electronic transmission intermediary, a pharmacy, or other similar entity shall not sell, license, or exchange for value regulated records containing prescriber-identifiable information, not permit the use of regulated records containing prescriber-identifiable information for marketing or promoting a prescription drug, unless the prescriber consents as provided in subsection (c) of this section. Pharmaceutical manufacturers and pharmaceutical marketers shall not use prescriber-identifiable information for marketing or promoting a prescription drug unless the prescriber consents as provided in subsection (c) of this section.

(e) The prohibitions set forth in subsection (d) of this section shall not apply to the following:

(1) the sale, license, exchange for value, or use, of regulated records for the limited purposes of pharmacy reimbursement, prescription drug formulary compliance; patient care management; utilization review by a health care professional, the patient's health insurer, or the agent of either; or health care research;

(2) the dispensing of prescription medications to a patient or to the patient's authorized representative;

(3) the transmission of prescription information between an authorized prescriber and a licensed pharmacy, between licensed pharmacies, or that may occur in the event a pharmacy's ownership is changed or transferred;

(4) care management educational communications provided to a patient about the patient's health conditions, adherence to a prescribed course of therapy and other information relating to the drug being dispensed, treatment options, recall or patient safety notices, or clinical trials;

(5) the collection, use, or disclosure of prescription information or other regulatory activity as authorized by chapter 84, chapter 84A, or section 9410 of this title, or as otherwise provided by law;

(6) the collection and transmission of prescription information to a Vermont or federal law enforcement officer engaged in his or her official duties as otherwise provided by law; and

(7) the sale, license, exchange for value, or use of patient and prescriber data for marketing or promoting if the data do not identify a prescriber, and there is no reasonable basis to believe that the data provided could be used to identify a prescriber.

(f) In addition to any other remedy provided by law, the attorney general may file an action in superior court for a violation of this section or of any rules adopted under this section by the attorney general. The attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Vermont consumer fraud act, chapter 63 of Title 9. Each violation of this section or of any rules adopted under this section by the attorney general constitutes a separate civil violation for which the attorney general may obtain relief. (Added 2007, No. 80, § 17; amended 2007, No. 89 (Adj. Sess), § 3, eff. March 5, 2008.)

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

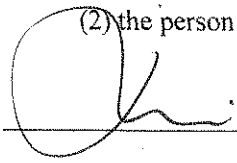
I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

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

6/8/11
Date

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

JUN 13 2011

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary)

Theiler
Applicant's Printed Last Name

Regan N
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

6/8/11
Date of Signature

NOTARY

Dated 6/8/11 Signed Pam Simmons

State of Texas County of Galveston

SUBSCRIBED AND SWORN TO before me this 8th day of, June 2011.

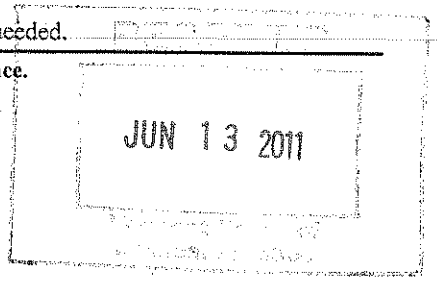
My commission expires: 1-25-2013 (NOTARY PUBLIC SIGNATURE & SEAL)

PAMELA A. SIMMONS
NOTARY PUBLIC STATE OF TEXAS
COMMISSION EXPIRES:
01-25-2013

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.



This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

Name of Applicant: Regan Theiler

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Theiler was at UTMB, Galveston

From July, 2007 to July, 2011. During that time, he/she was (List status in the Institution): faculty

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____Poor	____Fair	____Average	✓ Above Average
Professional judgment:	____Poor	____Fair	____Average	✓ Above Average
Sense of responsibility:	____Poor	____Fair	____Average	✓ Above Average
Moral character/ ethical conduct:	____Poor	____Fair	____Average	✓ Above Average
Competence and skill:	____Poor	____Fair	____Average	✓ Above Average
Cooperativeness, ability to work with others:	____Poor	____Fair	____Average	✓ Above Average
History & physical exam taking:	____Poor	____Fair	____Average	✓ Above Average
Record keeping:	____Poor	____Fair	____Average	✓ Above Average
Case presentations:	____Poor	____Fair	____Average	✓ Above Average
Patient management:	____Poor	____Fair	____Average	✓ Above Average
Physician-Patient Relationship:	____Poor	____Fair	____Average	✓ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____Poor	____Fair	____Average	✓ Above Average
Participation in Medical Staff Affairs	____Poor	____Fair	____Average	✓ Above Average

Addendum 4A, Continued

Name of Applicant: Regan Theiler

How long have you known the applicant and in what capacity? 3 years 1 colleague

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	✓ Yes ___ No
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine?	___ Yes ✓ No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	___ Yes ✓ No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.)	___ Yes ✓ No
Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	___ Yes ✓ No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	___ Yes ✓ No
Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	___ Yes ✓ No
Do you know of a failure to complete a residency training program(s)?	___ Yes ✓ No
Does the applicant call upon consults when needed?	✓ Yes ___ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other – Specify: ___

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Regan Nell Theiler, MD for licensure in Vermont.
Name of Physician

Signed: [signature] Date: 6-8-2017

Print or Type Name and Title: Trisha Wood Muir MD

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.

This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

Name of Applicant: Regan Theiler

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Regan Theiler was at UTMB

From 7/2007 to 6/2011. During that time, he/she was (List status in the Institution): Faculty, Ob/Gyn

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____Poor	____Fair	____Average	↘ Above Average
Professional judgment:	____Poor	____Fair	____Average	↘ Above Average
Sense of responsibility:	____Poor	____Fair	____Average	↘ Above Average
Moral character/ ethical conduct:	____Poor	____Fair	____Average	↘ Above Average
Competence and skill:	____Poor	____Fair	____Average	↘ Above Average
Cooperativeness, ability to work with others:	____Poor	____Fair	____Average	↘ Above Average
History & physical exam taking:	____Poor	____Fair	____Average	↘ Above Average
Record keeping:	____Poor	____Fair	____Average	↘ Above Average
Case presentations:	____Poor	____Fair	____Average	↘ Above Average
Patient management:	____Poor	____Fair	____Average	↘ Above Average
Physician-Patient Relationship:	____Poor	____Fair	____Average	↘ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____Poor	____Fair	____Average	↘ Above Average
Participation in Medical Staff Affairs	____Poor	____Fair	____Average	↘ Above Average

Addendum 4A, Continued

Name of Applicant: Regan Theiler

How long have you known the applicant and in what capacity? Division Director

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	↘ Yes ____ No
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine?	____ Yes ↘ No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	____ Yes ↘ No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.)	____ Yes ↘ No
Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	____ Yes ↘ No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	____ Yes ↘ No
Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	____ Yes ↘ No
Do you know of a failure to complete a residency training program(s)?	____ Yes ↘ No
Does the applicant call upon consults when needed?	↘ Yes ____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- ↘ Close personal observation
- ____ General impression
- ____ A composite of faculty/staff evaluations
- ____ Other – Specify: ____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Regan Theiler for licensure in Vermont.
Name of Physician

Signed: [signature] MD Date: 6/13/11

Print or Type Name and Title: Russell Snyder MD
Director Division Gynecology
Dept OB/Gyn
Univ Tx Medical Branch @ Galveston

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.

This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

Name of Applicant: Regan Theiler

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Theiler was at UTMB

From 7/2007 to 6/2011. During that time, he/she was (List status in the Institution): Faculty, Ob/Gyn

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	____Poor	____Fair	____Average	✓ Above Average
Professional judgment:	____Poor	____Fair	____Average	✓ Above Average
Sense of responsibility:	____Poor	____Fair	____Average	✓ Above Average
Moral character/ ethical conduct:	____Poor	____Fair	____Average	✓ Above Average
Competence and skill:	____Poor	____Fair	____Average	✓ Above Average
Cooperativeness, ability to work with others:	____Poor	____Fair	____Average	✓ Above Average
History & physical exam taking:	____Poor	____Fair	____Average	✓ Above Average
Record keeping:	____Poor	____Fair	____Average	✓ Above Average
Case presentations:	____Poor	____Fair	____Average	✓ Above Average
Patient management:	____Poor	____Fair	____Average	✓ Above Average
Physician-Patient Relationship:	____Poor	____Fair	____Average	✓ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____Poor	____Fair	____Average	✓ Above Average
Participation in Medical Staff Affairs:	____Poor	____Fair	____Average	✓ Above Average

Addendum 4A, Continued

Name of Applicant: Regan Theiler

How long have you known the applicant and in what capacity? 4 years

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	✓ Yes ___ No
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine?	___ Yes ✓ No
Do you know of any pending professional misconduct proceedings or medical malpractice claims?	___ Yes ✓ No
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.)	___ Yes ✓ No
Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?	___ Yes ✓ No
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	___ Yes ✓ No
Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	___ Yes ✓ No
Do you know of a failure to complete a residency training program(s)?	___ Yes ✓ No
Does the applicant call upon consults when needed?	✓ Yes ___ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other – Specify: ___

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Regan Theiler for licensure in Vermont.
Name of Physician

Signed: [signature] Date: 16 June 11

Print or Type Name and Title: Professor & Chairman

GEORGIA COMPOSITE MEDICAL BOARD

EXECUTIVE DIRECTOR
LaSharn Hughes, MBA

BOARD CHAIRPERSON
Alexander S. Gross, MD

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723
http://www.medicalboard.georgia.gov E-Mail: Medbd@dch.ga.gov

Wednesday, June 15, 2011

RE: **Regan Theiler, MD**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a license by the Georgia Composite Medical Board.

It is further certified that:

The license number is **305** and was issued on **July 2, 2004**

The current license status is **Lapsed**

The license expiration date is **June 30, 2007.**

Board Actions A review of public records indicates that no public board orders have been docketed.

Certified this day Wednesday, June 15, 2011.

Georgia Composite Medical Board

LaSharn Hughes
Executive Director

LLH/

1114

Licensure Verification Form **Form #1**
(Copy this form for multiple licenses)

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: Vermont

TO BE COMPLETED BY APPLICANT

Applicant Name: Theiler (Last) Regan (First) Nell (Middle) (Suffix)

Date of Birth: [redacted] Social Security Number: [redacted] License Number: 000305
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of Georgia to furnish the information to the Board indicated below.

Signature of Applicant [signature] Date 6/8/11

Board Name: Vermont Board of Medical Practice

Address: 108 Cherry St, P.O. Box 70 (Street) Burlington (City) VT (State/Province) 05401 (ZIP Code)

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: (Last) (First) (Middle) (Suffix)

License Type: License #: Issue Date: Expiration Date:

Is this license current? ☐Yes ☐No If No, please explain:

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐Yes ☐No ☐Cannot answer under state law
If Yes, please explain:

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain:

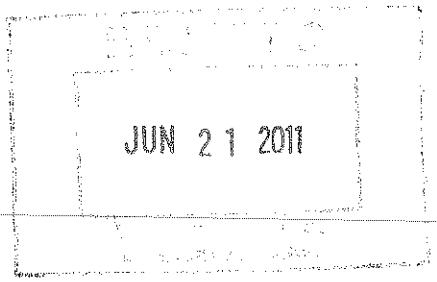
Affix Board Seal Here

Board Authorized Signature:

Title:

Date:

Please return this form to the Board listed at the top of this form.



Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

VERMONT BOARD OF MEDICAL PRACTICE LICENSING AND REGISTRATION
108 CHERRY ST.
BURLINGTON, VT 05402-0070

June 16, 2011

For: VERMONT BOARD OF MEDICAL PRACTICE LICENSING AND REGISTRATION

In response to a recent request, we verify the following information:

****

Physician: REGAN NELL THEILER, MD
License: M6911
Date Issued: 06/08/2007
Licensed by:
Date of Birth: [redacted]
Medical School: UNIV OF WISCONSIN MED SCH, MADISON
Graduation Year: 2003
Permit Expires: 02/28/2013

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

****

If you have any further questions, please contact the Hearings division

Sincerely,

Customer Information Center

BOARD SEAL

UNIVERSITY OF WISCONSIN-MADISON

The Board of Regents of the University of Wisconsin System,
on the nomination of the faculty, has conferred upon

REGAN NELL THEILER

The Degree of

DOCTOR OF MEDICINE

Together with all honors, rights, and privileges belonging to that degree.
In witness whereof, this diploma is granted.

Given at Madison in the State of Wisconsin
this eighteenth day of May in the year two thousand and three
and of the University the one hundred fifty-third.

SEAL
VERIFIED

Katharine Lyall
President, University of Wisconsin System

Jon D. Wilcox
Chancellor, University of Wisconsin-Madison

Lucy A. Mitchell
President of the Board of Regents

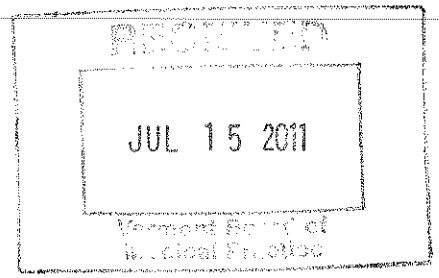
I certify that this is a true and correct copy of the original diploma of Regan Nell Theiler, M.D.

Sharon J. Greuel
Certification Officer

SEAL
VERIFIED

REGAN N. THEILER, MD, PHD, FACOG

CURRICULUM VITAE
July 11, 2011



PRESENT POSITION AND ADDRESS:

2007-Present Assistant Professor
Division of Gynecology
Department of Obstetrics and Gynecology
University of Texas Medical Branch
Galveston, Texas 77555-0587
409/370-9644
rntheile@utmb.edu

BIOGRAPHICAL:

Sex: Female
Date of Birth: October 26, 1973
Place of Birth: Osseo, Wisconsin
Citizenship: U.S.A.

EDUCATION:

2003-2007 Residency. Emory University, Atlanta Georgia
Department of Obstetrics and Gynecology

1996-2003 M.D. University of Wisconsin-Madison Medical School, Madison, Wisconsin
Medical Scientist Training Program

1998-2001 Ph.D. University of Wisconsin-Madison, Madison, Wisconsin
Microbiology Doctoral Training Program

1992-1996 B.S. DePaul University, Chicago, Illinois
Chemistry, with High Honor

PROFESSIONAL AND TEACHING EXPERIENCE:

2007-Present Assistant Professor and Women's Reproductive Health Research (WRHR) Scholar
Division of Gynecology, Department of Obstetrics and Gynecology, University of Texas Medical Branch, Galveston, Texas

2008-2011 Staff Physician, Planned Parenthood Gulf Coast, Houston, Texas

2006-2007 Administrative Chief Resident, Department of Gynecology and Obstetrics
Emory University, Atlanta, Georgia

2005-2007 CDC Guest Researcher, Centers for Disease Control and Prevention

Atlanta, Georgia

2003-2006 Resident, Department of Gynecology and Obstetrics
Emory University, Atlanta, Georgia

1995 National Science Foundation Fellowship, Research Experience for Undergraduates
University of Utah Medical Center and Department of Chemistry
Bacterial Topoisomerases as Antimicrobial Targets

CERTIFICATION:

2009 Diplomate, American Board of Obstetrics and Gynecology
2010 Fellow, American Congress of Obstetricians and Gynecologists

LICENSURE:

Texas State Medical License – M6911

RESEARCH ACTIVITIES:

Interests include maternal/fetal infectious diseases, virology, and placental immunology.

2007-Present Women's Reproductive Health Research Scholar
National Institutes of Health K12 Mechanism
Principle Investigator: Gary D. V. Hankins, MD
Mentors: C. J. Peters, M.D. and Mahmoud Ahmed, PhD

2007-2011 National Institutes of Health Loan Repayment Program (LRP) for Clinical Researchers

2004-2005 Roche Diagnostics Grant: Cord Blood Screening for Cytomegalovirus Infection Using Quantitative PCR.

COMMITTEE ASSIGNMENTS:

2001-2003 Medical Scientist Training Program Admissions Committee, University of Wisconsin-Madison School of Medicine, Madison, Wisconsin

2005-2007 Residency Oversight Committee, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia

2006-2007 Graduate Medical Education Resident Duty Hours Subcommittee, Emory University School of Medicine, Atlanta, Georgia

2006-2007 Graduate Medical Education Committee, Emory University School of Medicine, Atlanta, Georgia

2008-2009 Surgical Care Improvement Project Committee, John Sealy Hospital, University of Texas Medical Branch, Galveston, Texas

2008-Present Pharmacy and Therapeutics Committee, John Sealy Hospital, UTMB, Galveston, Texas

2009-Present Obstetrics and Gynecology Electronic Medical Records Committee.

2010-Present Obstetrics and Gynecology Education Committee

TEACHING RESPONSIBILITIES:

2009-Present Ob/Gyn Residents: Director of gynecology rotation for Ob/Gyn residents

2008-Present Small Group Facilitator – Ob/Gyn Clerkship – 3rd Year Students

2008-Present Practice of Medicine Course Facilitator and Lecturer

2009 Problem Based Learning Facilitator

MEMBERSHIP IN PROFESSIONAL AND SCIENTIFIC SOCIETIES:

2008-Present Society for Gynecologic Investigation

2009-Present Infectious Disease Society of America

1996-Present American Medical Association

2007-Present American Society for Microbiology

HONORS:

1992-1996 Arthur J. Schmitt Scholar, DePaul University, Chicago, Illinois

1993 CRC Freshman Chemist of the Year Award, Department of Chemistry, DePaul University, Chicago, Illinois

1993, 94, 96 Dean's Award for Academic Excellence, DePaul University, Chicago, Illinois

1994-1996 Claire Booth Luce Scholarship for Women in Math and Science, DePaul University, Chicago, Illinois

1996 Merck Index Award, Department of Chemistry, DePaul University, Chicago, Illinois

1998-2000 National Research Service Award, Molecular Biosciences Training Grant T32 GM 07215, University of Wisconsin-Madison Graduate School, Madison, Wisconsin

2001-2003 Wisconsin Distinguished Rath Graduate Fellow in Medicine, University of Wisconsin-Madison School of Medicine, Madison, Wisconsin

2005	Carlos Moisa Research Recognition Award, Department of Gynecology and Obstetrics, Emory University, Atlanta, Georgia
2006	Second Place – Resident Research Day, Department of Gynecology and Obstetrics, Emory University, Atlanta, Georgia
2007	Golden Apple Award, Emory University Medical Student Teaching Award, Emory University, Atlanta, Georgia
2008	Charles C. Shepard Science Award Finalist – Laboratory and Methods Manuscript "Breast Milk CD4+ T Cells Express High Levels of Chemokine Receptor 5 and CXC Chemokine Receptor 4 and are Preserved in HIV-Infected Mothers Receiving Highly Active Antiretroviral Therapy". (Journal of Infectious Diseases 2007; 195:965-972) June 2008
2010	McGanity Lectureship, Texas Association of Obstetrics and Gynecology Annual Meeting

OTHER AFFILIATIONS:

2008-Present	Member – UTMB Sealy Center for Vaccine Development
2009	Legislative Affairs Consultant to the University of Texas System
Ongoing	Peer reviewer (*ad hoc*) for:

Infectious Diseases in Obstetrics and Gynecology
Journal of the American Medical Association (JAMA)
The American Journal of Obstetrics and Gynecology
The American Journal of Public Health
The Journal of Clinical Virology
The Journal of Travel Medicine

2010-Present	Consultant to Bayer pharmaceuticals: Speakers bureau
2010-Present	Consultant to Merck pharmaceuticals: Implanon faculty trainer

MENTORSHIP:

Undergraduate Students:

1. Kyle O'Boyle. Summer undergraduate research program, 2008.

Medical Students:

1. Emiko Petrosky. Senior research elective, 2009-10.
2. Holly Dunn. Senior research elective, 2009-10.

Graduate Students:

1. Janet Appleton. PhD student 2009-10.
2. Reagan Street. Masters of Medical Science, 2010.

Residents:

1. Sara Mucowski, M.D. Resident research project, 2008-2011.
2. Paula Doyle, M.D. Resident research project, 2008-2010.
3. Katie Gillaspy, M.D. Resident research project, 2008-2010.
4. Teresa Walsh, M.D. Resident research project, 2010-ongoing.
5. Katheryn Williams, M.D. Resident research project, 2010-ongoing.
6. Johanna Voutyras, M.D. Resident research project, 2011-ongoing.

Advisory Committee Memberships:

1. Nguyen V. Nguyen, medical student honors thesis
2. Dara Havemann, M.D. Masters of Medical Science

BIBLIOGRAPHY:

ARTICLES IN PEER-REVIEWED JOURNALS

1. **Theiler, R.N.** and Compton, T.: Characterization of the Signal Peptide Processing and Membrane Association of Human Cytomegalovirus Glycoprotein O, *Journal of Biological Chemistry*, 2001; 276:39226-39231. PMID: 11504733. Impact factor: 5.32.

2. Kinzler, E*., **Theiler, R.N*.** and Compton, T.: Expression and Reconstitution of the gH/gL/gO Complex of Human Cytomegalovirus, *Journal of Clinical Virology*, 2002; Supplement 2: S87-S94. PMID: 12361760. Impact factor: 3.12. *These authors contributed equally.

3. **Theiler, R.N.** and Compton, T.: Distinct Glycoprotein O Complexes Arise In a Post-Golgi Compartment of Cytomegalovirus-Infected Cells, *Journal of Virology*, 2002; 76:2890-2898. PMCID135985. Impact factor: 5.15.

4. Salani, R., **Theiler, R.N.**, and Lindsay, M.: Uterine Torsion and Fetal Bradycardia Associated with External Cephalic Version, *Obstetrics and Gynecology*, 2006; 108:820-22. PMID: 17018516. Impact factor: 4.35.

5. Jamieson, D.J., **Theiler, R.N.**, and Rasmussen, S.A.: Emerging Infections and Pregnancy, *Emerging Infectious Diseases*, 2006; 12:1657-62. PMID: 17283611. Impact factor: 6.79.

6. **Theiler, R.N.**, Caliendo, A., Pargman, S., Berga, S., Raynor, B.D., and Jamieson, D.J.: Umbilical Cord Blood Screening for Cytomegalovirus DNA by Quantitative PCR, *Journal of Clinical Virology*, 2006; 37:313-16. PMID: 17035082. Impact factor: 3.12.

7. Kourtis, A.P., Ibegbu, C., **Theiler, R.N.**, Xu, Y., Bansil, P., Jamieson, D.J., Lindsay, M., Butera, S., Duerr, A.: Breast milk CD4+ T cells express high levels of C chemokine receptor 5 and CXC chemokine receptor 4 and are preserved in HIV-infected mothers receiving highly active antiretroviral therapy, *Journal of Infectious Disease*, 2007; 195:965-72. PMID: 17330786. Impact factor: 5.86.

8. **Theiler, R. N.** Evidence-based antimicrobial therapy in pregnancy: long overdue. *Clinical Pharmacology and Therapeutics*, 2009; 86:237-38. PMID: 19707213. Impact factor: 6.96.

9. **Theiler, R. N.**, Farr, S.L., Karon, J.M., Paramsothy, P., Viscidi, R., Duerr, A., Cu-Uvin, S., Sobel, J., Shah, K., Klein, R.S., and Jamieson, D.J. High risk HPV reactivation in HIV-infected

women: risk factors for cervical viral shedding. Obstetrics and Gynecology, 2010;115: 1150-58. Impact factor: 4.36.

10. Street, R.M., Mucowski, S.J., Gillaspy, K. R., Snyder, R.R., and **Theiler, R.N.** Dystroglycan expression in human placenta: basement membrane localization and subunit distribution change between the first and third trimester. *Accepte for publication*: *Reproductive Sciences*.

INVITED PUBLICATIONS

1. **Theiler, R.N.**, Rasmussen, S.A., Treadwell, T., and Jamieson, D.J.: Emerging and Zoonotic Infections in Women. *Infectious Disease Clinics of North America*, 2008; 22:755-772.

2. Ward, K., and **Theiler, R.N.**: Once-Daily Dosing of Gentamicin in Obstetrics and Gynecology. *Clinical Obstetrics and Gynecology*, 2008; 51(3):498-506.

3. Fox, K., and **Theiler, R.N.** Vaccination in Pregnancy. *Current Pharmaceutical Biotechnology*, 2011; 12: 789-796.

ABSTRACTS

1. Regan N. Theiler and Teresa Compton, Characterization of the Membrane Orientation of Human Cytomegalovirus Glycoprotein O. Oral Presentation at Wisconsin-Purdue Virology Conference (WISPUR), Argonne National Laboratory, Chicago, Illinois, 1999.

2. **Regan N. Theiler** and Teresa Compton, Characterization of the Membrane Association of Human Cytomegalovirus Glycoprotein O, A Component of the Viral Fusion Machinery. Keystone Symposium on Cell Biology of Virus Entry, Replication, and Pathogenesis, Taos, New Mexico, 2000.

3. **Regan N. Theiler,** Eric R. Kinzler, and Teresa Compton, Characterization and Reconstitution Of the Tripartite Envelope Complex, gH/gL/gO, of HCMV. Oral Presentation at 8th International Cytomegalovirus Conference, Monterrey, California, 2001.

4. **Regan N. Theiler** and Teresa Compton, Characterization of a Tripartite Fusion Glycoprotein Complex of Human Cytomegalovirus. Oral Presentation at the American Society for Virology, 20th Annual Meeting, Madison, Wisconsin, 2001.

5. **Regan N. Theiler,** A. Caliendo, S. Pargman, M. McPheeters, S. Berga, B.D. Raynor and D.J. Jamieson, Umbilical Cord Blood Screening for Cytomegalovirus DNA by Quantitative PCR. Oral Presentation at International Infectious Disease Society for Obstetrics and Gynecology USA (I-IDSOG) Meeting, Alexandria, Virginia, 2006.

6. **Regan N. Theiler** and C.J. Peters, Lymphocytic Choriomeningitis (LCMV) Model of Congenital Viral Infection and Immunity. Women's Reproductive Health Research Meeting, Rochester, New York, 2008.

7. Janet Appleton and **Regan N. Theiler**. Characterization of Lymphocytic Choriomeningitis Virus Infection of Human Placenta. Society for Gynecologic Investigation (SGI) 57th Annual Meeting, Orlando, Florida, 2010.

8. Sara J. Mucowski, Reagan M. Street, and **Regan N. Theiler**. The Role of α-Dystroglycan in Placentation. Society for Gynecologic Investigation (SGI) 57th Annual Meeting, Orlando, Florida, 2010.

9. **Regan N. Theiler**, Shaleen Theiler, and C.J. Peters. Viral Replication and Immune Response Differ after Infection of First vs. Third Trimester Human Placenta. Society for Gynecologic Investigation (SGI) 58th Annual Meeting, Miami Beach, Florida, 2011.

10. Reagan Street and **Regan N. Theiler.** Dystroglycan Expression in Gynecologic Cancers. Society for Gynecologic Investigation (SGI) 58th Annual Meeting, Miami Beach, Florida, 2011.

Renewal - 042.0012264

Name	Regan Nell Theiler
Credential	042.0012264

Fee Details

	$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@vdh.state.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
- print legibly or type your answers
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to "yes" answers in Parts II - IV
- write your name and license number on each attachment
- do not delegate this important task to any other person. False statements on this form may be grounds for charges of unprofessional conduct.

Be sure to submit:

- completed application
- completed Form A
- completed *Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions*, whether or not you have children.
- any other attachments
- 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:
Theiler

2. First Name:
Regan

3. Middle Name:
Nell

4. Have you ever legally changed your name?
No

5. If yes, enter your former name and other name(s) under which you were licensed in Vermont or elsewhere:

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

6. Date of Birth:
[redacted]

7. Enter your MAILING ADDRESS information:

Attention

Street 128 Lakeside Avenue,Suite 301

City BURLINGTON **State** VT **Zip** 05401 **Country** United States

E-mail Address

Telephone (802) 448-9700 **Alternate Phone (e.g. Pager)**

8. Enter your PUBLIC ACCESS address information:

Attention

Street 128 Lakeside Avenue,Suite 301

City BURLINGTON **State** VT **Zip** 05401

Country United States

Telephone (802) 448-9700

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 Vermont or any other state?
Yes

11. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Texas	MD	M6911	09/01/2007	02/28/2013	Active
New Hampshire	MD	15363	08/03/2011	06/30/2013	Active
Maine	MD	018899	08/03/2011	12/31/2013	Active

12. Medical Professional Schools [26 VSA § 1368(a)(7)]
Please provide the names of medical professional schools you attended and the dates of graduation.

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
EMORY UNIVERSITY	01/01/2007	Obstetrics and Gynecology

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
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/2009	

15. **Years of Practice**
What year did you start practicing as a medical professional?
2007

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

Facility Name	State	Start Date
Fletcher Allen Healthcare	Vermont	09/01/2011

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

17. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
No

18. State:

19. Year:

20. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

21. Denied certificate to practice medicine or any other healing art - Upload documents

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
No

23. State:

24. Year:

25. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:

26. Please upload any documents you have that are relevant to this matter.

27. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
No

28. State:

29. Year:

30. Circumstances:

31. Please upload any documents you have that are relevant to this matter.

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

33. Name of organization involved:

34. Date:

35. Duration:

36. Action Taken (add all that apply):

37. Circumstances:

38. Please upload any documents you have that are relevant to this matter.

39. Have you ever been denied the privilege of taking an examination before any state medical examining board?
No

40. State:

41. Year:

42. Circumstances under which examination privileges denied:

43. Please upload any documents you have that are relevant to this matter.

44. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
No

45. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:

46. Discontinued Education, Training, or Clinical Practice - Upload documents:

47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?
No

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances:

52. Please upload any documents you have that are relevant to this matter.

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

54. Institution involved:

55. Location:

56. Year:

57. Circumstances:

58. Please upload any documents you have that are relevant to this matter.

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

60. Name of organization involved:

61. Type of restriction:

62. Date:

63. Circumstances of restriction

64. Please upload any documents you have that are relevant to this matter.

65. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice.
No

66. Please provide a general description of your practice of internet prescribing:

67. Are you presently, or have you ever been, a defendant in a criminal proceeding?
No

68. Court:

69. City and state:

70. Charge:

71. Description:

72. Status:

73. Date:

Renewal Part III

PART III

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

Any "yes" response to the questions below must be fully explained.

74. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?

75. Licensing or certification board:

76. Date:

77. Location of Licensing Board:

78. Circumstances:

79. Please upload any documents you have that are relevant to this matter.

MEDICAL DEFINITIONS

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

[redacted]

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

82. Please upload any documents you have that are relevant to this matter.

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

[redacted]

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

85. Please upload any documents you have that are relevant to this matter.

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

[redacted]

87. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

88. Please upload any documents you have that are relevant to this matter.

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

89. Treating organization:

90. Address:

91. Telephone:

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

93. Dates of illness or dependency (from, to):

94. Dates of treatment (from, to):

95. Name of rehabilitation/professional assistance or monitoring program:

96. Address:

97. Telephone:

98. Contact person at Program:

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

Renewal Part IV

Statutory Profile Questions

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

It is very important for us to receive 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 actions taken.

If you have been convicted of an alcohol or drug related crime, you must contact the Vermont Practitioners Health Program to arrange for a confidential evaluation (802-223-0400). The evaluation will need to be received by this Board prior to licensure.

99. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets)? For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction.

No

100. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description

101. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Have there been any charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction?

No

102. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continue without finding by a court of competent jurisdiction.

Date of Charges	Court	City	State	Description of Charges

103. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have there been any formal charges served, findings, conclusions, and/or orders of the Board of Medical Practice (including stipluations), and/or final disposition of such matters by the courts, if appealed?

No

104. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipluations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary

105. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have there been any formal charges served against you by licensing or certification authorities of other states?

No

106. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please**

provide copies of papers fully documenting these matters.

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

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

108.
A. Revocation/Involuntary Restrictions
Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please upload copies of papers fully documenting these matters.

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

109. Have your hospital privileges ever been restricted, or have you ever resigned or not renewed your medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital?
No

110.
B. Other Restrictions
Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please upload copies of papers fully documenting these matters.

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

111. **Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]** Have you ever been involved in a Malpractice Liability Claim? Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.
No

112.
A. Judgments
Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Date of Judgment

113.
B. Settlements Please provide a description of all settlements of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

Date Of Settlement

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

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

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

School	City	State	Nature of Appointment	Year Started	Year Ended

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

School/Institution	City	State	Nature of Teaching	Year Started	Year Ended

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

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

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/2009	

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?
None reported	Williston	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 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:
08/30/2012

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:

08/30/2012

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 - 042.0012264

Name	Regan Nell Theiler
Credential	042.0012264

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:
Theiler

2. First Name:
Regan

3. Middle Name:
Nell

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 [redacted]
Telephone [redacted] **Alternate Phone (e.g. Pager)** [redacted]

9. Enter your PUBLIC ACCESS address information:

Attention
Street One Medical Center Drive
City Lebanon **State** NH **Zip** 03756
Country United States
Telephone
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?
Yes

12. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Texas	MD	M6911	09/01/2007	02/28/2013	Active

New Hampshire	MD	15363	08/03/2011	06/30/2013	Active
Maine	MD	018899	08/03/2011	12/31/2013	Active

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: University of Wisconsin **State**: Wisconsin **Country**: United States **School Type**: Medical School **Degree**: MD	05/01/2003

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
EMORY UNIVERSITY	01/01/2007	Obstetrics and Gynecology

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
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/2009	

16. **Years of Practice**
What year did you start practicing as a medical professional?
2007

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

Facility Name	State	Start Date
Mary Hitchcock Memorial Hospital	New Hampshire	05/01/2013

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.
No

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

118. **C. Pending Cases**
Provide the information requested in the following table for each case that is currently pending against you.

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

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

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?
Dartmouth-Hitchcock Medical Center	lebanon	New Hampshire	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:
09/04/2014

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 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.

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:
09/04/2014

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