## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1996-1998 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE ONE OF FOUR

I hereby apply for the RENEWAL of my CERTIFICATION AS A PHYSICIAN'S ASSISTANT for the period from 02/01/96 to 01/31/98. TWO YEAR RENEWAL FEE: \$55.

Enclose a check in the amount of \$55. made payable to the Vermont Board of Medical Practice.

095-0030098

Amv 5. Borgman PA-C Planned Parenthood of Northern N.E. 90 Washington Street Barre, UT 05641

Important:

- Please print legibly or type your answers.

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

### SECTION I

1. Name: Any S. BORGMAN	2. Vermont Certification Number: 55- <u>০০৪০</u> ৭
3. Other Name(s), if any, under which you were certified or licer	nsed in Vermont and elsewhere:
4. Home Address:	
City, State, Zip Cod	Management of any control of the con
5. Office Address: 90 WASHINGTON 3T	
City, State, Zip Code: BARRE UT 05641	
6. Daytime Telephone Number: Area Code: ( \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	6.6676
7. Date of Birth: Month:	DayYear
8. Place of Birth:	9. Sex: MaleFemale
10. Certification Examination Taken - Check: NCCPA Other Examination Specify:	State Examination-Identify State:
11. Basis for Vermont Certification: ApprenticeshipUniversity Tra	•
12. Undergraduate Degree - Circle: B.A. B.S. A.B. Other	Year of Graduation: 19 82
Degree Granting Institution: G WU	
First Institution (If transfer):	Location:
P.A. Diploma or Certificate:  Other:	Year of Graduation:
School: Location:	

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1996-1998 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE TWO OF FOUR

13. Do you have hospital privileges in Vermont?YesNo Name(s) and Location(s) of Hospital(s):	,
14. Did you practice in Vermont during the past 12 months?	
15. Other states where you now hold an active certification or license to practice:	
17. Specialty: DEA Number: NA	•
18. Name and office address of current employer: Name Address	
PPNDE 70 WASHINGTON St. Bane UT 05641	•
19. Please review the attached list of current Primary and Secondary Supervising Physicians. In Information correct? Yes No if no, contact the Board. If no list is attached, please the information below:  Name, specialty and office address of Supervising Physician(s):  Specialty Address	s the fill out
20. Name, specialty and office address of the Secondary Supervising Physician(s):  Name Specialty Address	
21. Please attach a copy of your NCCPA certificate.	
22. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice (see attached definition) for your practice setting attention to any additions or deletions in duties and procedures. a) Has there been a change in your sepractice which has not been reviewed by the Board Yes No b) Please review, sign and CPA and PRIMARY SUPERVISING PHYSICIAN your scope of practice. Please attach a copy of your scope of practice.	cope of late by
23. Documentation showing practice as a Physician's Assistant within the past twelve months: Please letter from your Supervising Physician attesting to the fact that you have practiced as a Physician's Asswithin the past twelve months.	provide a istant
An applicant for certification renewal who has not practiced as a Physician's Assistant for more than two months must submit a satisfactory evaluation by the Supervising Physician prior to renewal.	elve
24. Continuing Medical Education (CME) requirements: a. NCCPA certified Physician's Assistants: Attach proof of recertification; this will serve as adequate pro	of of
b. For all others, enclosed please find an explanation of requirements and a logging form. If you have	any

25. All Physician's Assistants are required to have a Secondary Supervising Physician for their practice. We have enclosed a form to be returned to this office if you do not have a Secondary Supervising Physician on file with our office.

questions, please address them in writing to Board Member Jack Cassidy, P.A. at the Board's address.

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1996-1998 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE THREE OF FOUR

### SECTION II: PLEASE CHECK YES OR NO.

A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A. Important note regarding the following questions: Except for questions 1 and 4, "Yes" answers on past certification renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1996-1998 period if the answer to any of the questions below changes from "No" to "Yes". (Section II is for the reporting of information which is retained solely by the Board of Medical Practice and is not part of the data base maintained by the Department of Health.)

## During the past TWO YEARS:

Daining the pact 1470 127110.		•
1. Have you had any organic illness, emotional disturbance or mental illness which has practice as a physician's assistant or to function as a physician's assistant student, resi		
2. Have you been a defendant in any criminal proceeding other than minor traffic offens	es?	YES NO
3. Are you currently under investigation for a criminal act?		
4. Have you been dependent upon alcohol or drugs?		
5. Are any formal disciplinary charges pending or has any disciplinary action ever been governmental authority, by any hospital or health care facility, or by any professional phassociation (international, national, state or local)?	ysician's a	
6. Has any medical malpractice claim been made against you (whether or not a lawsuit the claim/complaint/demand for damages)?		in relation to
7. Have you had staff privileges, employment or appointment in a hospital or other heat reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary actimedical staff after a complaint or peer review action has been initiated against you?		gned from a
8. Have you voluntarily surrendered or resigned a license or certification to practice as any healing art in lieu of disciplinary action?		n's assistant or NO
9. Has your privilege to possess, dispense or prescribe controlled substances been sus restricted or surrendered by any jurisdiction or federal agency at any time?	pended, re YES	evoked, denied,
10. Have you been denied the right to participate or enroll in any system whereby a thir a patient's bill?		ys all or part of
11. Have you withdrawn an application for physician's assistant certification or license, or physician's assistant certification or license for any reason?		enied a NO
12. Have you been turned down for coverage by a malpractice insurance carrier?	YES	NO
13. Have you been notified as a responsible party of a confirmed quality concern (quality provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?	y of hospi	tal care
14. Have you been the subject of an investigation by any other licensing board?		7.
15. Have you been dismissed or asked to leave a residency training program(s)	VEQ	NO

## SECTION III: STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1996-1998 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FOUR OF FOUR

### Applicant's Statement Regarding Child Support

Title 15 § 795 requires that the following statement be completed by anyone applying for a license, certification or registration to practice a profession in the state of Vermont.

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

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

	nave children.
	t hereby certify that I am not subject to any support order or am in good standing with respect to or in full compliance with plan to pay any and all child support due under a support order as of the date of this application.
	I hereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship" to the address below.
	Applicant's Statement Regarding Taxes
•	3113 requires that this form must be completed by anyone applying for a license, certification or registration to practice a in the state of Vermont.
he or she appeal, th	ional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on e taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority s that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
	You must check one of the two statements below regarding taxes:
	I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship" to the address below.
will be use	curity #
	Statement of Applicant
to the bes	ertify that all the information contained in this renewal application (including all pages and attachments) is true and accurate it of my knowledge. Failure to provide truthful and accurate information may constitute grounds for denial of license renewal nary action.
Signature	of Applicant Date 12 12 95
	re completed form and fee to:  Vermont Board of Medical Practice  109 State Street  Montpelier, Vermont 05609-1106
Questions	s?: (802) 828-2673

proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of \$55\* in check or money order payable to the Vermont Board of Medical Practice. (Medical Board Renewal Fee \$50 + Office of Professional Regulation (OPR) Fee: \$5.00 = \$55. OPR's \$5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

important: Please be sure to write your certification number on your check. Check for the correct spelling of your name and

\*Note: Physician's Assistants 80 years of age or older are exempt from payment of a renewal fee; however the Physician's Assistant certification renewal application must be completed and submitted.

# National Commission on Certification of Physician Assistants, Inc.

IF ANY INFORMATION ON THIS VERIFICATION IS INCORRECT, PLEASE CONTACT NCCPA.

830420

AMY S. BORGMAN

NATIONAL COMMISSION CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

has met the requirements for certification and is entitled to use the designations

PHYSICIAN ASSISTANT-CERTIFIED and PA-C

Expiration Date:

This card is for identification purposes only and does not constitute proof of certification. For verification, please contact NCCPA.

Physician's Assistant Renewal 1996-1998

Please review the list of Primary and Secondary Supervisors below. If these do not correspond with your records, please contact Debbie Morehouse, Administrative Assistant, at the Board Office (802) 828-2422.

Amy S. Borgman, PA-C 55-0030098

Employer:

Planned Parenthood of Northern New England

23 Mansfield Avenue

Burlington, Vermont 05401

Work Sites:

90 Washington Street, Barre, Verrmont 05461 41 South Main Street, Randolph, Vermont 05060

Primary Supervisor:

Judith Tyson, M.D.

Secondary Supervisor: Cheryl Gibson, M.D.

## PRIMARY SUPERVISING PHYSICIAN APPLICATION

Submit in typewritten form. Incomplete applications will be returned. Attach additional sheets as needed. Name in full Gibson Cheryl (Middle) (Former) Mailing Address Women's Choice Gynecologic Associates (City) 23 Mansfield Ave. Burlington, VT 05401 863-9001 (State) (Zip Code) (Phone) Office Address \_\_\_\_same\_as\_above (Street) (City) (State) (Zip Code) (Phone) Number of years you have been practicing Medicine: 11 Vermont License # 42-0007465 **JOSPITAL(S) NAME WHERE YOU HAVE PRIVILEGES:** HOSPITAL(S) LOCATION SPECIALTY Fletcher Allen Health Care Burlington, VT OB/GYN LIST ALL PHYSICIAN'S ASSISTANTS NAMES AND ADDRESSES YOU CURRENTLY SUPERVISE: Secondary Supervising Physician for: Amy Borgman, August Burns, Sue Burton, Joanne Gutt, Hanna Hauser, Cate Nichols, Belle Travers, Mary Wallmyn, Judy Wechsler Vhat arrangments have you made for supervision when you are not available or out of town: PPNNE's medical director, Judy Tyson MD, is also a Primary Supervising Physician for PPNNE's Physician Assistants. In the event we are both unavailable, an acting Medical Director is appointed to supervise PPNNE Physician Assistants. CERTIFICATE OF SUPERVISING PHYSICIAN hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities Amy Borgman ,P.A. while under my supervision. I further certify that the protocol outlining ne scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify tat a notice will be posted that a physician's assistant is used, in accordance with 26 NSA, chapter 31 section 1741.

Vermont Secretary of State's Office, Board Of Medical Practice, Pavilion Office Building Montpelier Vermont 05602 Telephone - (802)828-2363

(Signature of Applicant)

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

## SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

	•		•	
Name in full	Smith Su	usan		
	(Last)	(First)	(Middle)	(Last)
Mailing Addrage	· Women's	Choice Gyneco	ologic Associates	
Mennik Venicss	(Street)	9,1200	(City)	
	(00000)	•	(City)	
<del></del>	23 Mansf		Burlington, VT 05401	863-9001
	(State)	(Zip Code)	(Phone)	
Office Address_	same as	above		
***	(Street)		(City)	
			•	•
**************************************	(State)	(Zip Code)	(Phana)	
	•	(Eib Code)	(Phone)	
mont License #: 42-	-0005990	Number of years	you have been practicing Med	licine: 19
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SPITAL(S) NAME V	VHERE YOU H	IAVE PRIVILEGES	HOSPITAL(S) LOCATION	SPECIALTY
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ereby centry that, in a	ccordance with	26 VSA, Chapter 3	11, i shall be legally responsible	e for all medical activ
Kiny Dorginan	, P.A. or	nly when the super	ising physician is unavailable	and only when consu
ine atoresalo Physicia	an's Assistant.	I further certify that	the protocol outlining the score	e of practice, attache
application, does not	t exceed the no	ormal limits of my pr	actice and that in accordance	with 26 VSA, Chapter
tion 1741, the use of	i a physician's i	assistant has been	posted.	•
			W.	. ~
1-17-96			XIA. Mic	4 (11)
			_ Over Our	14 MY
(Date)			(Signature of Secondary St	pervising Physician)

## Planned Parenthood

of Northern New England

Standing Orders for Nurse Practitioners & Physician Assistants

The Family Planning Practitioner may:

Date Effective: January 1996

- Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; A. common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.
- Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol. В. 1)

Manage routine hormonal contraceptive and HRT problems. 2)

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

2) Manage routine Norplant problems.

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

2) Manage routine DMPA problems.

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

2) Manage routine IUD problems.

- 3) Order X-rays and sonograms for IUD localization.
- Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol. F. 1)

Manage diaphragm and cervical cap problems. 2)

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

2) Manage condom and spermicide problems.

- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-H. thermal, cervical mucus and calendar.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate Ĭ. laboratory and other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
- Administer parenteral medications in accordance with the PPNNE Medical Protocol. These medications J. specifically are:

Atropine

Cefoxitin

Ceftriaxone

Diphenhydramine (Benadryl)

Diptheria, Tetanus vaccine

Diphtheria, Tetanus, Pertussis vaccine

Epinephrine

Gentamicin

Hepatitis B vaccine

Influenza vaccine

Lidocaine

Measles, Mumps, Rubella vaccine

Medroxyprogesterone acetate (Depo-provera)

Methylergonovine maleate (Methergine)

Penicillin

Pitocin

Pneumococcus vaccine

Progesterone

Rh immune globulin

Spectinomycin

Streptomycin

Tigan

Tuberculin skin test

Vancomycin

The following parenteral medications may be administered

under physician orders:

Diazepam (Valium)

Phenobarbital

Other Emergency Drugs

Order and dispense the following oral medications in accordance with PPNNE Medical Protocol: K.

Acetaminophen (Tylenol)

Acyclovir (Zovirax)

Amoxicillin

Ampicillin

A.S.A.

Azithromycin

Cefixime

Ciprofloxacin Clindamycin

Mefenamic acid (Ponstel)

Methylergonovine maleate (Methergine)

Metronidazole (Flagyl)

Naproxen sodium (Anaprox)

Nicorette gum

Nordette (for MAP only)

Norfloxacin Nystatin

Affarania

Conjugated estrogens (Premarin) Diphenhydramine (Benadryl)

Doxycycline
Erythromycin
Estradiol (Estrace)
Fenoprofen (Nalfon)
Ferrous Fumarate
Ferrous Gluconate
Ferrous Sulfate

Fluconazole Ibuprofen (Motrin, Nuprin, Advil)

Ipecac syrup Ketoconazole Ketorolac Macrodantin

Medroxyprogesterone acetate (Depo-provera)

Ovral (for MAP only)

Probenecid Pyridium

Pyridoxine (Vitamin B6) Sulfizoxazole (Gantrisin)

Tetracycline

Trimethoprim-sulfamethoxazole

(Bactrim, Septra)

Trivalent oral polio virus (TOPV)

And, all oral contraceptives currently stocked by PPNNE.

The following oral medications may be administered under

physician orders: Diazepam (Valium) Oxazepam (Serax)

L. Order, dispense and use the following topical medications in accordance with the PPNNE Medical Protocol:

Acigel

Acyclovir cream (Zovirax) Ammonia inhalant

Betadine vaginal preparations Butoconazole nitrate cream 2%

(Femstat)

Clindamycin vaginal cream

Clotrimazole cream, suppositories

(Mycelex, Gyne-Lotrimin)
Condylox topical solution
Conjugated Estrogen Cream
Crotamiton cream/lotion (Eurax)

Dienestrol Cream Estradiol Cream Estrogen patches Gentian violet Lugol's Solution

Metronidazole vaginal gel (MetroGel) Miconazole eream, suppositories (Monistat)

Monsell's solution (Ferric subsulfate)

Nicotine patches

Nystatin suppositories, tablets

Permethrin (Elimite 5%)

Podophyllin (various formulations)
Synthetic pyrethrins (A-200, RID)

Terconazole vaginal creams, suppositories (Terazol)

Transdermal Nicotine Systems

Trichloroacetic acid

Trimethobenzamide (Tigan) Suppositories Triple Sulfa creams, suppositories (Sultrin)

Xylocaine gel, ointment

- M. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
- N. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms.
- O. Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
- P. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.
- Q. Perform venipuncture; start and maintain I.V.'s.
- R. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.

The Family Planning Practitioner must:

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

I agree to practice under the above standing orders

Signature

Date

Collaborating Physician:

PPNNE - Form 44 12/95 vb

Judith Tyson, M.D., Medical Director, PPNNE



802 • 878-7232 FAX 602 • 678-8001

SERVING MAINE, NEW HAMPSHIRE & VERMONT

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

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

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

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

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

In 1994, we provided health care services to 19,646 patients in Vermont. While the majority of our clients are between the ages of 20 and 34, 15% of

our patients are teenagers, and 13% are over 35 years old. In addition, many of our clients are economically disadvantaged. In 1994, 56% of our Vermont patients had incomes less than 150% of federal poverty guidelines.

As specified in Section I, page 14 of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

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

Physician's Assistant:		
2 Sty Ph	Date:	1.19.96
Medical Director:		11 . / .
J. J Y Son MD	Date:	1124/96
	<del></del>	
Associate Medical Pirector:		/ /
Allem	Date: _	1/23/96
Susan Smith, M.D. Secondary Supervising	Physicia	an):
Ousan Mulh		1.24.96



802 • 878-7232 FAX 802 • 878-8001

SERVING MAINE, NEW HAMPSHIRE & VERMONT

### MEDICAL OVERSIGHT AT PPNNE

## Physician Oversight

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol and are approved by the Medical Director before functioning in an independent capacity. As part of a new practitioner's orientation, a "Practitioner Skills Assessment" checklist is completed. If further training in any expected area of competence is needed, this is arranged.

The Medical Director and Associate Medical Director provide oversight and supervision through on-site visits and consultations, telephone consultations, and quarterly in-services. They are available for telephone back-up on a 24-hour basis. In addition, the Medical Director works with the Affiliate Medical Committee, the Medical Management Team and the Director of Quality Assurance to develop and review protocols and audits and to evaluate any new developments in the medical field that may affect PPNNE. All PPNNE mid-level practitioners practice under standing orders developed by the Medical Director and approved by our Medical Committee. Practitioners attend quarterly continuing education in-service for medical training and discussion of protocol questions and other practice concerns.

We also have on staff a full-time Associate Medical Director, who is also a board certified OB/GYN. She is also available for consultation on a daily basis and to serve as Acting Medical Director when the Medical Director is on vacation or out of town. Both the Medical Director and Associate Medical Director visit sites on a regular basis for chart review and evaluation of patients with problems. In addition, we also have community physicians who are available to our staff for consultation, telephone back-up and periodic review of charts.

## Affiliate Medical Committee

The Affiliate Medical Committee, comprised of physicians and allied health providers from Maine, New Hampshire, and Vermont, meets two times per year, and is charged with assuring that the medical protocol under which PPNNE operates meets community standards and is in compliance with Planned Parenthood Federation of America (PPFA) national standards and guidelines. It is responsible for approving the protocols for any new medical service PPNNE undertakes, and for reviewing and recommending PPNNE's participation in any research project.

## Practice Protocols

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

## Medical Management Team

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

## Director of Quality Assurance

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

## 1. Quality Assurance Site Audit

The Director of Quality Assurance conducts an annual on-site evaluation of each clinic. This audit includes a comprehensive review of charts, laboratory and pharmacy logs and practitioner performance, as well as an evaluation of the safety of the clinic.

## 2. Medical Record and Patient Care Audits

Medical Record and Patient Care Audits are conducted three times each year. The specific audit topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topic include: follow-up of abnormal Pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

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

AHI BORGHAN

### VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

· To be completed only by physician's assistants practicing in Vermont.

The combined PA certification renewal application and survey form in your hands represents a collaborative effort between the Vermont Board of Medical Practice and the Vermont Department of Health to address the data/information needs of both (and others) in as efficient way as possible.

The Vermont Department of Health is seeking certain information from this survey to assess the distribution of provider resources in order to identify shortage areas. The data will also be used in developing the primary care section of the Health Resources Management Plan promulgated by the Vermont Health Care Authority. Input to Section IV has been solicited and obtained from the Vermont Health Care Authority, the Vermont Medical Society, the Vermont Hospital Association and the Primary Care Access Committee, among others. A Provider Registry, built from Sections I and IV is maintained in the Center for Public Health Statistics, Vermont Department of Health, with financial support from the Primary Care Cooperative Agreement and the Rural Health Programs, Vermont Department of Health. For additional information on survey uses call 1-802-863-7300.

Please try to fill in the survey as best as possible.

Thank you for your careful cooperation in this important effort.

## SECTION IV CONTINUED

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•	2 Group Practic	e: Single Specialty	8 Hospi	tal Emerger	ncy Room	ı • ·			
	3 Group Practic	e: Multi-Specialty	9 Hospi	9 Hospital Outpatient Clinic					
	4 FQHC/RHC (	Community Health Center	r 10 Hosp	10 Hospital Impatient					
- -	5 School or Col	lege Health Center	11 Exter	11 Extended Care Facility					
•	6 Business or V	Vonksite	. 12 Other	12 Other: Specify					
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	4 FQHC/RHC	Com	munity Health Cen	ier .	10 Hospital Inpatient					
	5 School or C	òllege	Health Center		11 Extended Care Facility					
	6 Business or	Work	site		12 Other: Specify					
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## SECTION IV CONTINUED

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## SECTION IV CONTINUED

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SPECIALTY CODES
( To be used with Section I, #17,19 and Section IV #7a-7d)

101	ALLERGY & IMPLINOLOGY		PATHOLOGY (BOARD NAME - NOT A SPECIALTY)
102	CLINICAL & LABORATORY INFUNOLOGY	1501	ANATOMIC & CLINICAL PATHOLOGY
		1502	ANATONIC PATHOLOGY
201	ANESTHESIOLOGY	1503	- CLINICAL PATHOLOGY
202	CRITICAL CARE MEDICINE	1504	BLOOD BANKING/TRANSFUSION MEDICINE
203	PAIN MANAGEMENT	1505	CHEMICAL PATHOLOGY
906.8	Startist She's to English the start and the	1506	CYTOPATHOLOGY
301	COLON & RECTAL SURGERY	1507	DERMATOPATHOLOGY
<b>4</b> 01	DERMATOLOGY	1508	FORENSIC PATHOLOGY
402	DERMATOPATHOLOGY	1509	HEMATOLOGY
403	CLINICAL & LABORATORY	1510 1511	IMMUNOPATHOLOGY MEDICAL MICROBIOLOGY
404	DERNATOLOGICAL INMUNOLOGY	1512	NEUROPATHOLOGY
		1513	PEDIATRIC PATHOLOGY
501	EMERGENCY MEDICINE		
502	MEDICAL TOXICOLOGY	. 1601	PEDIATRICS
503	PEDIATRIC EMERGENCY MEDICINE	1602	ADOLESCENT MEDICINE
<b>5</b> 04	SPORTS MEDICINE	1603	CLINICAL & LABORATORY IMMUNOLOGY
***		1604	MEDICAL TOXICOLOGY
601	FAMILY PRACTICE	1605	NEONATAL-PERINATAL NEDICINE
602	GERIATRIC MEDICINE	1606	PEDIATRIC CARDIOLOGY
603	SPORTS MEDICINE	1607	PEDIATRIC CRITICAL CARE MEDICINE
701	INTERNAL MEDICINE	1608	PEDIATRIC EMERGENCY MEDICINE
702	ADDLESCENT MEDICINE	1609 1610	PEDIATRIC ENDOCRINOLOGY
703	CARDIAC ELECTROPHYSIOLOGY	1611	PEDIATRIC GASTROENTEROLOGY PEDIATRIC HEMATOLOGY-ONCOLOGY
704	CARDIOVASCULAR DISEASE	1612	PEDIATRIC INFECTIOUS DISEASE
705	CRITICAL CARE MEDICINE	1613	PEDIATRIC NEPHROLOGY
706	CLINICAL & LABORATORY IMMUNOLOGY	1614	PEDIATRIC PULMONOLOGY
707	ENDOCRINDLOGY DIABETES & METABOLISM	1615	PEDIATRIC RHEUMATOLOGY
708	GASTROENTEROLOGY	1616	PEDIATRIC SPORTS MEDICINE
709	GERIATRIC MEDICINE		
710	HEMATOLOGY	1701	PHYSICAL MEDICINE & REHABILITATION
711	INFECTIOUS DISEASE		·
712	MEDICAL ONCOLOGY	1801	PLASTIC SURGERY
713	NEPHROLOGY	1802	HAND SURGERY
714 715	PULMONARY DISEASE	5000	
715 716	RHEUMATOLOGY SPORTS MEDICINE	1901	PREVENTIVE MEDICINE
6 109	arunia meninime	1902 1903	AEROSPACE MEDICINE OCCUPATIONAL MEDICINE
801	MEDICAL GENETICS	1904	PUBLIC HEALTH & GENERAL PREVENTIVE
802	CLINICAL BIOCHEMICAL GENETICS	1905	MEDICAL TOXICOLOGY
803	CLINICAL BIOCHEMICAL/MOLECULAR GENETICS	1906	UNDERSEAS MEDICINE
804	CLINICAL CYTOGENETICS	****	with a sum of a band
805	CLINICAL GENETICS (M.D.)		PSYCHIATRY & NEUROLOGY (BOARD NAME - NOT A
806	CLINICAL MOLECULAR GENETICS		SPECIALTY)
		2001	PSYCHIATRY
901	NEUROLOGICAL SURGERY	2002	NEUROLOGY
902	CRITICAL CARE MEDICINE	2003	NEUROLOGY W/ SPECIAL QUALIFICATIONS IN
466	ል መጀመር ነው	900 A	CHILD MEUROLOGY
1001	NUCLEAR MEDICINE	2004 2005	ADDICTION PSYCHIATRY
1101	DESTETRICS & GYNECOLOGY	2005 · 2006	CHILD & ADOLESCENT PSYCHIATRY
1102	CRITICAL CARE MEDICINE	2007	FORENSIC PSYCHIATRY GERIATRIC PSYCHIATRY
1103	GYNECOLOGIC ONCOLOGY	2008	CLINICAL NEUROPHYSIOLOGY
1104	MATERNAL & FETAL MEDICINE	- Approx	enter on the section of the section
1105	REPRODUCTIVE ENDOCRINOLOGY	2101	RADIOLOGY
	•••	2102	DIAGNOSTIC RADIOLOGY
1201	OPHTHALMOLOGY	~ 2103	RADIATION ONCOLOGY
		2104	RADIOLOGICAL PHYSICS
1301	ORTHOPAEDIC SURGERY	2105	NUCLEAR RADIOLOGY
1302	hand surgery	2106	PEDIATRIC RADIOLOGY
4/B6	arpai souimat gar	2107	VASCULAR & INTERVENTIONAL RADIOLOGY
1401	OTOLARYHGOLOGY	<b>ማ</b> ማረፍ	ites and profession
1402 1403	OTOLOGY/NEUROTOLOGY PEDIATRIC OTOLARYNGOLOGY	2201 2202	EXCERY
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		2204	PEDIATRIC SURGERY SURGICAL CRITICAL CARE
		22/5	Seneral Vascular Surgery
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	ON BACK		
	OIA PURCH	2401	LINOLOGY

# SPECIALTY CODES - CONTINUED ( To be used with Section I, #17, 19 and Section IV #7a-7d)

4001	ABDOMINAL SURGERY
4002	ACUPUNCTURE
4003	ADDICTION MEDICINE
4004	ADULT RECONSTRUCTIVE ORTHOPEDICS
<b>40</b> 05	ALLERGY
4006	CARDIOVASCULAR SURGERY
4007	CLINICAL PHARMACOLOGY
<b>4008</b>	DIABETES
4009	FACIAL PLASTIC SURGERY
4010	GENERAL PRACTICE
4011	SYNECOLOGY
4012 4013	HEAD & HECK SURGERY
	HEPATOLOGY
4014	HOMEOPATHIC MEDICINE
4015	INFUNOLOGY
4016	LEGAL MEDICINE
4017	MUSCULOSKELETAL ONCOLOGY
4018	NEURORAD I OLOGY
4019	NUTRITION
4020	OBSTETRICS
4021	
4022	ORTHOPEDIC SURGERY OF THE SPINE .
4023	ORTHOPEDIC TRAUMA
4024	PAIN MEDICINE
4025	PEDIATRIC ALLERGY
4026	PEDIATRIC OPHTHALMOLOGY
4027	PEDIATRIC ORTHOPEDICS
4028	PEDIATRIC SURGERY (NEUROLOGY)
4029	PEDIATRIC UROLOGY
4030	PSYCHOANALYSIS
4031	RADIDISOTOPIC PATHOLOGY
4032	SPORTS MEDICINE (ORTHOPEDIC SURGERY)
4033	TRAUMATIC SURGERY
9999	OTHER - PLEASE SPECIFY IN <u>ALL</u> PLACES WHERE THIS CODE IS USED

CODES CONTINUED ON FRONT

## SECTION IV CONTINUED

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	1 Solo Practice			·	7 Hospi	tal Owned/	Operated	Office Practice	
•	2 Group Practic	e: Singl	e Specialty	-	& Hospi	tal Emerge	ncy Roon	1	
	3 Group Practic	= Multi	-Specialty		9 Hospi	tal Outpatio	ent Clinic	•	
	4 FQHC/RHC	Commu	ity Health Cent	er .	10 Hospi	ital Impaties	nt	•	
* _ ·	5 School or Co	llege He	alth Center		11 Exter	ded Care F	acility		
•	6 Business or V	Vorksite	•	•	12 Other	Specify_	PLA	UNED PARA	in the compi
Please complete	one full line for e	ach SPE	CIALTY (bat Y	OÜ p	ractice at th	is site.	•	•	
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_			General geriate	ic me	dical care				
•			General gynec	ologic	al medical	Care	12.		•

August Burns

### VERMONT DEPARTMENT OF HEALTH SURVEY



### SECTION IV

To be completed only by physician's assistants practicing in Vermont.

The combined PA certification renewal application and survey form in your hands represents a collaborative effort between the Vermont Board of Medical Practice and the Vermont Department of Health to address the data/information needs of both (and others) in as efficient way as possible.

The Vermont Department of Health is seeking certain information from this survey to assess the distribution of provider resources in order to identify shortage areas. The data will also be used in developing the primary care section of the Health Resources Management Plan promulgated by the Vermont Health Care Authority. Input to Section IV has been solicited and obtained from the Vermont Health Care Authority, the Vermont Medical Society, the Vermont Hospital Association and the Primary Care Access Committee, among others. A Provider Registry, built from Sections I and IV is maintained in the Center for Public Health Statistics, Vermont Department of Health, with financial support from the Primary Care Cooperative Agreement and the Rural Health Programs, Vermont Department of Health. For additional information on survey uses call 1-802-863-7300.

Please try to fill in the survey as best as possible.

Thank you for your careful cooperation in this important effort.

### SECTION IV

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

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

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

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

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

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

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

## . SECTION IV CONTINUED

iame of Practice(	s): <u>PPA</u>	JUE .					•	
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	1 Solo Practice			7 Hospi	tal Owned/0	Operated	Office Practice	
	2 Group Practice	: Single Specialty	,	8 Hospi	tal Emerger	cy Room		
	3 Group Practice	: Multi-Specialty		9 Hospi	tal Outpatie	ent Clinic	•	<b>.</b>
	4 FQHC/RHC C	Community Health Cent	ter	10 Hosp	ital Inpatier	ıt	•	
	5 School or Coll	lege Health Center		11 Exter	ided Care F	acility	•	
	6 Business or W	orksite .		12 Other	Specify _			· .
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SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIEN CARE	Practice Setting	Do y cond pract speci	on plan to inne the fice of this laity for the 12 months? or NO	WIII you ac patient in t specialty? YES or NO	inis	Will you accept new <u>Medicald</u> patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
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General obstetric medical care

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1998-2000 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE ONE OF SEVEN

I hereby apply for the RENEWAL of my CERTIFICATION AS A PHYSICIAN'S ASSISTANT for the period from 02/01/98 to 01/31/2000. TWO YEAR RENEWAL FEE: \$50.

Enclose a check in the amount of \$50. made payable to the Vermont Board of Medical Practice.

055-003009a

Amy 5. Borgman PA-C Planned Parenthood of Northerd N.Z. 23 Mansfield Avenue Burlington, VT 80481

### Important:

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

Note: Physician's Assistants 80 years of age or older are exempt from payment of a renewal fee; however the Physician's Assistant certification renewal application must be completed and submitted.

ď

- Thank you for your cooperation.

### **SECTION I**

1. Name: Any S. Borchan 2. Vermont Certification Number: 55-003009
3. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:
4. Home Address:
City, State, Zip Code:
5. Office Address: 90 WASHINGTON ST
City, State, Zip Code: Barre UT 05036
6. Daytime Telephone Number: Area Code: ( ) とつしょくしゅん
7. Date of Birth: Month: Day Year
8. Place of Birth: 9. Sex; MaleFemale
10. Certification Examination Taken - Check:
State Examination-Identify State:
Other Examination Specify:
11. Basis for Vermont Certification: Apprenticeship Trained  Vulversity Trained

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1998-2000 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE TWO OF SEVEN

12. Undergraduate Degree - Circle	B.S.) A.B. C	other: Year of Graduation: 1982_	
Degree Granting Institution:	GEORGE W	ASHINGTON UNIVERSITY	
Location: WASH.DC			
First Institution (If transfer):		Location:	
		Year of Graduation:	
School:	Loca	ation:	
13. Do you have hospital privilege	s in Vermont?Y	es No	
Name(s) and Location(s) of Hospit	al(s):		
	WARAA.		
14. Did you practice in Vermont du	ring the past 12 months	? <u>X</u> YesNo	
15. Other states where you now ho	old an active certification	or license to practice:	
		to practice: ViRGINIA	
		DEA Number:	
18. Name and office address of o			
Name	Add	ress	
PPNNE		MANSFIELD AUE	
19. Please review the attached linformation correct? Yes information below:	st of current Primary a No If no, contact	nd Secondary Supervising Physicians. Is the the Board. If no list is attached, please fill out the	
Name, specialty and office addre	ss of Supervising Phy	rsician(s):	
Name	Specialty	Address	
Judith Tyson MD	00/640	PPNNESI TALCOTT Rd, WILLISTON, UT 0549	5
		Woman's Chaice 23 MANSFIELD AVE BURL. UT	
20. Name, specialty and office ac Name	dress of the Secondar Specialty	ry Supervising Physician(s): Address	
an HTIME WAZNE	ob/Gyn	woman's choice 23 mansfield Are, Buck UT	
		0540	) Department

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1998-2000 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE THREE OF SEVEN

- 21. Please attach a copy of your current NCCPA certificate.
- 22. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice (see attached definition) for your practice setting, paying attention to any additions or deletions in duties and procedures.

a) Has there been a change in your scope of practice which has not been reviewed by the Board?		7
Yes	_(No	)

- b) Please review, sign and date by **PA and PRIMARY SUPERVISING PHYSICIAN** your scope of practice. Please attach a copy of your signed scope of practice.
- 23. Documentation showing practice as a Physician's Assistant within the past twelve months: Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician's Assistant within the past twelve months.

An applicant for certification renewal who has not practiced as a Physician's Assistant for more than twelve months must submit a satisfactory evaluation by the Supervising Physician prior to renewal.

## 24. Continuing Medical Education (CME) requirements:

- a. NCCPA certified Physician's Assistants: Attach proof of recertification; this will serve as adequate proof of CME completion.
- b. For all others, enclosed please find an explanation of requirements and a logging form. If you have any questions, please address them in writing to Board Member Jacqueline R. Goss, PA-C at the Board's address.
- 25. All Physician's Assistants are required to have a Secondary Supervising Physician for their practice. We have enclosed a form to be returned to this office if you do not have a Secondary Supervising Physician on file with our office.

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1998-2000 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FIVE OF SEVEN

### SECTION II

SECTION	ON II - "Yes" answers to Questions 1 - 24 requires an explanation on the enclosed Form A. During the past two yea	rs:
1.	Have you ever applied for and been denied a certification/license to practice as a PA or any healing art?YesN	o.
2.	Have you ever withdrawn an application for a certification/license to practice as a PA or any healing art? Yes	10
3.	Have you ever voluntarily surrendered or resigned a certification/license to practice as a PA or any healing art in lieu of disciplinary action? YesNo	
4.	Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any government authority, by any hospital or health care facility, or by any professional PA association (international, national, state or local)? YesNo	ntal
5.	To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?	
6.	Have you ever been denied the privilege of taking an examination before any State Medical Examining Board? YesNo	
7.	Have you ever discontinued your education, training, or practice for a period of more than three months? YesNo	
8.	Have you ever been dismissed or asked to leave a residency training program(s) before completion?YesNo	
9.	Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduce suspended or revoked; resigned from a medical staff in lieu of disciplinary action; or resigned from a medical staff after a complaint or peer review action has been initiated against you? YesNo	ed,
10.	Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patien bill? YesNo	t's
11.	Have you ever been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? YesNo	
12.	Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relati to the claim/complaint/demand for damages)? YesiNo	on
13.	Have you ever been turned down for coverage by a malpractice insurance carrier?  Yes	
14.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restrict or surrendered by any jurisdiction or federal agency at any time?  Yes No	ted
15.	Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses (Note: DWI - Driving While Intoxicated - is NOT a minor offense)?  Yes No	
16.	To your knowledge, are you the subject of an investigation for a criminal act?  Yes	

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1998-2000 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE SIX OF SEVEN

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

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

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

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

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

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

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

- Do you have a medical condition which in any way impairs or limits your ability to practice as a PA in the safety? If "yes," please explain.

  Does your use of chemical substance(s) in any way impair or limit your ability to practice as a PA in the safety? If "yes," please explain.

  Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If "yes," please exp
- 20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If "yes," please explain.
- 21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibition or account of "yes," please explain.
- 22. Are you currently engaged in the illegal use of controlled substances?
- 23. If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If "yes," ple
- 24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paragoic or any other name hotic disorder?

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

# STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS Applicant's Statement Regarding Child Support

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

795)	ensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. §
1.	You <u>must</u> check one of the two statements below regarding child support regardless whether or not you have children:
<u> </u>	I hereby certify that, as of the date of this application: (a) am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
***************************************	I hereby certify that I am <u>NOT</u> in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".  Applicant's Statement Regarding Taxes
uniess th are due, i	3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed e person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or sing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You must check one of the two statements below:
	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".  Applicant's Statement Regarding Unemployment Compensation Contributions
or busine services or pains and all co section, a contribution on tribution contribution contrib	1378 requires that: No agency of the state shall grant, issue or renewal any license or other authority to conduct a trade as (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the dependition of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any intributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no one or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of one one due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the lioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in intributions due and payable would impose an unreasonable hardship.  You must check one of the two statements below regarding unemployment contributions or payments in lieu of
No.	unemployment contributions:  I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both).
	I hereby certify that I am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
axes and tr	sure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of the Department of Employment and Training, in the administration of tax laws, to identify individuals affected by such laws, and by the Office of Child Support.  STATEMENT OF APPLICANT
certify the providing	at the information stated by me in this application is true and accurate to the best of my knowledge. I understand that false information of only information is unlawful and may jeopardize my license/certification/registration status.
Signature	of Applicant Date 1.5.98

## SECTION IV

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

	·
	(a) Check all of the activities that describe your current status as a physician:  Active in clinical practice in Vermont  Active in clinical practice outside Vermont  Administration  Teaching  Research  Retired  Other  (b) How many hours per week do you spend on administration, teaching and research?  hours
2.	Postgraduate training in Vermont:  (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?  _Yes No Note: If you answered YES, please answer questions (b) and (c)  (b) Are you aResidentClinical FellowResearch Fellow?  (c) What is the medical school that you are affiliated with for this training? University of VermontDartmouthOther (Please specify)
<b>*</b> *:	* <u>Note:</u> If you are providing patient care in Vermont, <u>CONTINUE</u> .  Otherwise, <u>STOP</u> and return this survey with your relicensing application.
3.	What is the date you started practicing medicine (excluding residency or fellowship training)?  (Month/Year)  9182
۱. <sup>۱</sup>	What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?  (Month/Year) 9/85
5.	Do you plan to retire or reduce your patient care hours in the next 12 months?YesNo

* Be as detailed as possible	are not available  K SITE section  arate site, hospit  patient/office set  le.  sheet to make si	for each location where you tals and nursing homes who tring.	ou provide patient care. ere you provide care to patients Code and Specialty Name colun	nns.
6(a). WORK SITE: NUMBER O	<u>NE</u>			
Town: Bark Ut		Cour	nty: _ WASHINGTON	
(*Note: Enter the town and county	n which the site	is located, not a mailing a	ddress or Post Office box.)	
Check the ONE practice setting from Solo Practice Group Practice Community Health Center Hospital Outpatient Cline School or College Health Business or Work Site	er or Clinic (Nor	PRACTICE SETTING  Hos  Hos  n-Hospital)  Ext	spital Emergency Room spital Inpatient ended Care Facility / Nursing Ho er: Specify	
Please complete one full line for each	h SPECIALTY	that YOU practice at this	AMBULATORY CARE patients who originate fro on-call hours.	that you spend at this site ENT CARE. Include both and HOSPITAL CARE of om this site. Please exclude
			7. C.	Hours
	Specialty Code		<b>a</b>	Per
Primary Specialty at this Site	1101	06/640	Specialty Name	Week
Secondary Specialty at this Site				
Other Specialty at this Site				
Do you plan to continue practice at a Will you accept new patients at this Will you accept new Medicaid patie	site? Yes	No	No	
Will you accept new Medicare patie				
Are you working with physician's as If yes, enter the number of: Physicia	ssistants and/or n n's Assistants <u>\</u>	nurse practitioners at this s	ite? Yes _No s _ NP	
For FAMILY and GENERAL PRAC care services to adolescents (ages 10	CTITIONERS, P	EDIATRICIANS and INT		ou provide primary

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

Instructions for completing this portion:  * Estimate if exact figures are not available.  * Please complete a WORK SITE section for each locat  * Do not include, as a separate site, hospitals and nursin normally seen in an outpatient/office setting.  * Be as detailed as possible.  * Use the enclosed yellow sheet to make selections for the point of the p	ng homes where you provide care to patients
6(b). WORK SITE: <u>NUMBER TWO</u>	
Town: PANDOCH  (*Note: Enter the town and county in which the site is located, no	County:ORANGE_ of a mailing address or Post Office box.)
Check the ONE practice setting from the selections below that m  PRACTIC  Solo Practice Group Practice Community Health Center or Clinic (Non-Hospital) Hospital Outpatient Clinic School or College Health Center Business or Work Site	ost accurately reflects your practice at this site:  CE SETTINGS  Hospital Emergency Room Hospital Inpatient Extended Care Facility / Nursing Home Other: Specify
	Average hours per week that you spend at this site providing DIRECT PATIENT CARE. Include both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please exclude on-call hours.

				Average hours per week that y providing DIRECT PATIENT AMBULATORY CARE and I patients who originate from the on-call hours.	CARE. Include both HOSPITAL CARE of
Please complete one full line for each	h SPECIALTY th	nat YOU practice at t	his site:		
Primary Control of the control of th	Specialty Code		Specialt	ty Name	Hou Per Wee
Primary Specialty at this Site	1101	06/(C)	4N, )		8
Secondary Specialty at this Site		. \_			
Other Specialty at this Site					
Do you plan to continue practice at Will you accept new patients at this Will you accept new Medicaid patie	site? Yes	_No _YesNo	esNo		
Will you accept new Medicare patie	ents at this site?	YesNo	1-1	~-	
Are you working with physician's a If yes, enter the number of: Physician	ssistants and/or nu un's Assistants <u>l</u>	urse practitioners at the Murse Practition	his site?Y	esNo	
For FAMILY and GENERAL PRActare services to adolescents (ages 10	CTITIONERS, PE 0-20) at this site?_	EDIATRICIANS andYesNo	INTERNISTS	S (primary care): Do you p	provide primary
For FAMILY and GENERAL PRA- site?Prenatal care and delive	CTITIONERS: W.	hich of the following tal care only	g obstetrical ser No obstetric	rvices do you provide to p cal services provided	vatients from this

Instructions for completing this portion:

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

Town:			County:		
(*Note: Enter the town and county	in which the site	is located, not a r	nailing address o	r Post Office box.)	· · · · · · · · · · · · · · · · · · ·
Check the ONE practice setting from Solo Practice Group Practice Community Health Center Hospital Outpatient Cline School or College Health Business or Work Site	om the selections ter or Clinic (Nor	below that most a PRACTICE S	accurately reflect: ETTINGS  Hospital En Hospital Inp	s your practice at this site: nergency Room patient are Facility / Nursing Home	
				Average hours per week that you spend at providing DIRECT PATIENT CARE. Inc AMBULATORY CARE and HOSPITAL (patients who originate from this site. Pleas on-call hours.	lude both CARE of
Please complete one full line for ea	ich SPECIALTY	that YOU practic	e at this site:		$\overline{}$
	Specialty Code		Speci	alty Name	Hour Per Week
Primary Specialty at this Site					
Secondary Specialty at this Site					
Other Specialty at this Site					
Do you plan to continue practice a Will you accept new patients at thi Will you accept new Medicaid pat Will you accept new Medicare pate.  Are you working with physician's If yes, enter the number of: Physic	s site?Yes  lents at this site? _  lents at this site? _  assistants and/or i	NoYesNoYesNo nurse practitioner	s at this site?	Yes No	
For FAMILY and GENERAL PRA care services to adolescents (ages )	ACTITIONERS, F (0-20) at this site?	PEDIATRICIANS	S and INTERNIS o	TS (primary care): Do you provide pri	

Instructions	for	completi	no this	portion:

- ons for completing this portion:

  \* Estimate if exact figures are not available.

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

6(c). WORK SITE: NUMBER F	OUR				
Town:			Commen		
(*Note: Enter the town and county	in which the si	te is located, not a	a mailing address or	Post Office box.)	
Check the ONE practice setting from the selections  Solo Practice Group Practice Community Health Center or Clinic (Non-Hospital Outpatient Clinic School or College Health Center Business or Work Site		s below that most PRACTICE	accurately reflects your practice at this site:		
				Average hours per week that you s providing DIRECT PATIENT CAI AMBULATORY CARE and HOS patients who originate from this sit on-call hours.	RE. Include both PITAL CARE of
Please complete one full line for each	ch SPECIALT	Y that YOU practi	ice at this site:		
	Specialty Code		Specia	lty Name	Hour Per
Primary Specialty at this Site			Opecia	ry rvame	Week
Secondary Specialty at this Site					
Other Specialty at this Site					
Do you plan to continue practice at Will you accept new patients at this Will you accept new Medicaid patie	site?Yes	No			
Will you accept new Medicare patie	ints at this site?	YesN	0		
Are you working with physician's a If yes, enter the number of: Physicia	ssistants and/or an's Assistants	nurse practitione Nurse P	ers at this site?	esNo	
For FAMILY and GENERAL PRAGE SERVICES to adolescents (ages 10)	CTITIONERS, 0-20) at this site	PEDIATRICIAN:?Yes1	NS and INTERNIST No	S (primary care): Do you prov	ide primary
For FAMILY and GENERAL PRAG	CTITIONERS:	Which of the foll	lowing obstetrical se No obstetri	rvices do you províde to patie cal services províded	nts from this



802 • 878-7232 FAX 802 • 878-8001

SERVING MAINE, NEW HAMPSHIRE & VERMONT

#### MEDICAL OVERSIGHT AT PPNNE

#### Physician Oversight

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol and are approved by the Medical Director before functioning in an independent capacity. As part of a new practitioner's orientation, a "Practitioner Skills Assessment" checklist is completed. If further training in any expected area of competence is needed, this is arranged.

The Medical Director and Associate Medical Director provide oversight and supervision through on-site visits and consultations, telephone consultations, and quarterly in-services. They are available for telephone back-up on a 24-hour basis. In addition, the Medical Director works with the Affiliate Medical Committee, the Medical Management Team and the Director of Quality Assurance to develop and review protocols and audits and to evaluate any new developments in the medical field that may affect PPNNE. All PPNNE mid-level practitioners practice under standing orders developed by the Medical Director and approved by our Medical Committee. Practitioners attend quarterly continuing education in-service for medical training and discussion of protocol questions and other practice concerns.

We also have on staff a full-time Associate Medical Director, who is also a board certified OB/GYN. She is also available for consultation on a daily basis and to serve as Acting Medical Director when the Medical Director is on vacation or out of town. Both the Medical Director and Associate Medical Director visit sites on a regular basis for chart review and evaluation of patients with problems. In addition, we also have community physicians who are available to our staff for consultation, telephone back-up and periodic review of charts.

#### Affiliate Medical Committee

The Affiliate Medical Committee, comprised of physicians and allied health providers from Maine, New Hampshire, and Vermont, meets as needed, and is charged with assuring that the medical protocol under which PPNNE operates meets community standards and is in compliance with Planned Parenthood Federation of America (PPFA) national standards and guidelines. It is responsible for approving the protocols for any new medical service PPNNE undertakes, and for reviewing and recommending PPNNE's participation in any research project.

#### **Practice Protocols**

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

#### Medical Management Team

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

#### Director of Quality Assurance

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

#### 1. Quality Assurance Site Audit

The Director of Quality Assurance conducts an annual on-site evaluation of each clinic. This audit includes a comprehensive review of charts, laboratory and pharmacy logs and practitioner performance, as well as an evaluation of the safety of the clinic.

#### 2. Medical Record and Patient Care Audits

Medical Record and Patient Care Audits are conducted three times each year. The specific audit topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topic include: follow-up of abnormal Pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

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

#### Planned Parenthood

#### of Northern New England

#### Standing Orders for Nurse Practitioners & Physician Assistants

The Family Planning Practitioner may:

Date Effective: September 1997

- Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common A. gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.
- Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol. В,
  - Manage routine hormonal contraceptive and HRT problems. 2)
  - 3) Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.
- C. Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol. 1)
  - Manage routine Norplant problems. 2)
- Inject Medroxyprogesterone acetate (Depo-provera) in accordance with PPNNE Medical Protocol. D. 1)
  - 2) Manage routine DMPA problems.
- E. Insert and remove IUD's in accordance with the PPNNE Medical Protocol. 1)
  - 2) Manage routine IUD problems.
  - 3) Order X-rays and sonograms for IUD localization.
- F. 1) Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol.
  - 2) Manage diaphragm and cervical cap problems.
- Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol. G. 1)
  - Manage condom and spermicide problems. 2)
- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical H. mucus and calendar.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and ı. other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
- Administer parenteral medications in accordance with the PPNNE Medical Protocol. These medications specifically are: J.

Atropine

Cefoxitin

Ceftriaxone

Diphenhydramine (Benadryl) Diptheria, Tetanus vaccine

Diphtheria, Tetanus, Pertussis vaccine

Epinephrine Gentamicin

Hepatitis B vaccine

Influenza vaccine

Lidocaine

Measles, Mumps, Rubella vaccine

Medroxyprogesterone acetate (Depo-provera) Methylergonovine maleate (Methergine)

Penicillin

Pitocin

Pneumococcus vaccine

Progesterone

Rh immune globulin

Spectinomycin

Streptomycin

Tigan

Tuberculin skin test

Vancomycin

The following parenteral medications may be administered under

physician orders: Diazepam (Valium)

Phenobarbital

Other Emergency Drugs

K. Order and dispense the following oral medications in accordance with PPNNE Medical Protocol:

Acetaminophen (Tylenol)

Acyclovir (Zovirax)

Amoxicillin

Ampicillin

A.S.A.

Azithromycin

Cefixime

Ciprofloxacin

Clindamycin

Conjugated estrogens (Premarin)

Diphenhydramine (Benadryl)

Mefenamic acid (Ponstel)

Methylergonovine maleate (Methergine)

Metronidazole (Flagyl)

Naproxen sodium (Anaprox)

Nicorette gum

Nordette (for MAP only)

Norfloxacin Nystatin Ofloxacin

Ovral (for MAP only)

Probenecid

Doxycycline Erythromycin Estradiol (Estrace) Fenoprofen (Nalfon) Ferrous Fumarate

Ferrous Gluconate

Ferrous Sulfate Fluconazole

Ibuprofen (Motrin, Nuprin, Advil)

Ipecac syrup Ketoconazole Ketorolac Macrodantin

Medroxyprogesterone acetate (Depo-provera)

Pyridium

Pyridoxine (Vitamin B6) Sulfizoxazole (Gantrisin)

Tetracycline

Trimethoprim-sulfamethoxazole

(Bactrim, Septra)

Trivalent oral polio virus (TOPV)

And, all oral contraceptives currently stocked by PPNNE.

The following oral medications may be administered under

physician orders: Diazepam (Valium)

Oxazepam (Serax)

L. Order, dispense and use the following topical medications in accordance with the PPNNE Medical Protocol:

Acigel

Acyclovir cream (Zovirax)

Ammonia inhalant

Betadine vaginal preparations Butoconazole nitrate cream 2%

(Femstat)

Clindamycin vaginal cream Cleocin Vaginal Cream

Clotrimazole cream, suppositories

(Mycelex, Gyne-Lotrimin)
Condylox topical solution
Conjugated Estrogen Cream
Crotamiton cream/lotion (Eurax)

Dienestrol Cream Estradiol Cream

Dimethyl Ether (Histofreeze)

Estrogen patches

Gentian violet

Lugol's Solution

Metronidazole vaginal gel (MetroGel) Miconazole cream, suppositories (Monistat)

Monsell's solution (Ferric subsulfate)

Nicotine patches

Nystatin suppositories, tablets

Permethrin (Elimite 5%)

Podophyllin (various formulations) Synthetic pyrethrins (A-200, RID)

Terconazole vaginal creams, suppositories (Terazol)

Transdermal Nicotine Systems

Trichloroacetic acid

Trimethobenzamide (Tigan) Suppositories Triple Sulfa creams, suppositories (Sultrin)

Xylocaine gel, ointment

- M. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
- N. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms.
- O. Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
- P. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.
- Q. Perform venipuncture; start and maintain I.V.'s.
- R. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- S. Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

The Family Planning Practitioner must:

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

I agree to practice under the above standing orders

Signature

Form 44 9/97 bd

Date

Collaborating Physician: Judith Tyson, MD, Medical Director, PPNNE

Cheryl Gibson, MD, Assoc, Med, Dir.



802 • 878-7232 FAX 802 • 878-8001

SERVING MAINE, NEW HAMPSHIRE & VERMONT

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

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

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

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

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

In 1996, we provided health care services to 20,575 patients in Vermont. While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged. In 1996, 60% of our Vermont

patients had incomes less than 150% of federal poverty guidelines. As specified in Section I, page 16 of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

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

Physician's Assistant:	
J. Sborr	Date: 1/13/98
Medical Director:	
Jul & Tysu MD	Date: 12/29/97
Associate Medical Director:	Date: 12/30/97
Susan Smith, M.D. (Secondary Superv	vising Physician):
Dusan Hund	Date:/6/96

## National Commission on Certification of Physician Assistants, Inc.

NCCPA requires certificate reregistration, which includes 100 hours of continuing medical education, every two years in order to maintain certification.

This verifies that:

AMY S BORGMAN

Has met the requirements and is reregistered.

Certificate No.:

830420

Expiration Date: JUNE 1, 1999

Executive Vice President

This verification extends the validity of the NCCPA certificate until the indicated expiration date, and is only valid when accompanied by the

THE ABOVE VERIFICATION OF REREGISTRATION VALIDATES THE NCCPA CERTIFICATE FOR THE NEXT TWO YEARS.

IF ANY INFORMATION ON THIS VERIFICATION IS INCORRECT, PLEASE CONTACT NCCPA.

830420 AMY S. BORGMAN **NATIONAL COMMISSION** 

CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

BORGMAN

has met the requirements for certification and is entitled PHYSICIAN ASSISTANT-CERTIFIED and PA-C

Certificate No.: Expiration Date: 830420

This card is for identification purposes only and does not constitute proof of certification. For verification, please contact NCCPA.

72554-97

TOTAL FORMS & SYSTEMS



802 • 878-7232 FAX 802 • 878-8001

SERVING MAINE, NEW HAMPSHIRE & VERMONT

January 19, 1998

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

#### Dear Friends:

This is to certify that the Physician's Assistants named below have practiced as Physician's Assistants under my supervision in Vermont within the last twelve months.



In addition, the Physician's Assistants named above will be authorized to prescribe medications in accordance with the Scope of Practice submitted to and approved by the Vermont Board of Medical Practice. Practitioners at Planned Parenthood of Northern New England do not independently prescribe or dispense controlled drugs and therefore are not required to obtain an identification number from the federal Drug Enforcement Agency (DEA).

Sincerely,

Judy Tyson, M.D. Medical Director



### State of Vermont

### Office of the Secretary of State

## Professional Certificate

I hereby certify that the following named persons are fully qualified to practice
as a Physician's Assistant
in the State of Vermont.

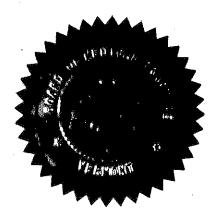
Amy S. Borgman, PA-C

P.A. Certification Number: 55-0030098

Valid only while working under the supervision of Judith Tyson, M.D.; Cheryl Gibson, M.D.; and Susan Smith, M.D. at Planned Parenthood of Northern New England, 90 Washington Street, Barre. Vermont and other Planned Parenthood of Northern New England offices in Vermont.

Under the Scope of Practice approved by the Vermont Board of Medical Practice.

Valid through January 31, 1998.



IN TESTIMONY	WHEREOF, I	I have hereunto	set my hand an	ıd
affixed the officia	l seal of			

. Vermont Board of Medical Practice

(Regulating Board or Court)

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

Administrative Assistant

1/26/96 Vicense Pent from renewal



#### PROFESSIONAL CERTIFICATE

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

Amy S. Borgman, PA-C

P.A. Certification Number: 55-0030098

Valid only while working under the supervision of Cheryl A. Gibson, M.D. and Susan F. Smith, M.D. at Planned Parenthood of New England, 90 Washington Street, Barre, VT.

Valid through January 31, 2004.



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

#### VERMONT BOARD OF MEDICAL PRACTICE

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

this

24th

of

January

, A.D. 2002

Administrative Assistant



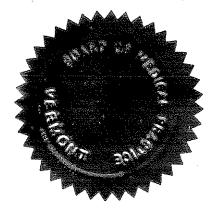
#### STATE OF VERMONT BOARD OF MEDICAL PRACTICE

#### PROFESSIONAL CERTIFICATE

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

Amy S. Borgman, PA-C
P.A. Certification Number: 55-0030098
Valid only while working under the supervision of Judith Tyson,
M.D.; Cheryl Gibson, M.D. and Susan Smith, M.D. at Planned
Parenthood of Northern New England, 90 Washington Street, Barre,
Vermont.

Valid through January 31, 2002.



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

#### VERMONT BOARD OF MEDICAL PRACTICE

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

this 1st day of February , A.D., 2000

Administrative Assistant

amy Borgman - 30098

PA CHECK LIST (RENEWAL) - 2000-2002

1. Fee 15'

2. Application pages complete

3. Child/Tax/Unemployment

4. Form A when applicable

5. NCCPA or CME proof

6. Signed (by both) Scope of Practice

7. Supervisor Statement

Survey-Veg A- NO \_

Pd 15

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2000-2002 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE ONE OF SIX

I hereby apply for the RENEWAL of my CERTIFICATION AS A PHYSICIAN'S ASSISTANT for the period from 02/01/00 to 01/31/02. TWO YEAR RENEWAL FEE: \$75. with each additional renewal \$50. Enclose a check in the amount of \$75. made payable to the Vermont Board of Medical Practice.

035-0030098

Amy 5. Borgman PA-C Planned Parenthood of Northern N.Z. 23 Mansfield Avenue Burlington, VT 05401



#### Important:

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

Note: Physician's Assistants 80 years of age or older are exempt from payment of a renewal fee; however the Physician's Assistant certification renewal application must be completed and submitted.

- Thank you for your cooperation.

#### **SECTION I**

1. Name: Amy SBORCMAN 2. Vermont Certification Number: 55-0030098
3. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:
4. Home Address:
City, State, Zip Code:
5. Office Address: 90 WASHINGTON ST
City, State, Zip Code: 3 000 UT 05641
Note: Circle your preferred mailing address. Please note that this address will be public and listed on the Board's website
6. Daytime Telephone Number: Area Code: (802) 476-6-16
7. Date of Birth: Month: Day Year
8. Place of Birth: 9. Sex: MaleFemale
10. Certification Examination Taken - Check:
NCCPA
State Examination-Identify State: Other Examination Specify:
11. Basis for Vermont Certification: Apprenticeship Trained University Trained

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2000-2002 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE TWO OF SIX

12. Undergraduate Degree - Circ	ole: B.A.) B.S. A.B. Ot	ther: Year of Graduation: 1973
Degree Granting Institution:	3 UNY @ Alban	<u> </u>
Location: & Albann 1		
مرب	•	Location:
P.A. Diploma or Certificate:	BS Other:_	Year of Graduation: 1982
School: CROCCE WASHING	STOD UNIVERSITY LOCA	ition: WASH DC
13. Do you have hospital privileg	ges in Vermont?Y	es (No)
Name(s) and Location(s) of Hos	pital(s):	
·		
14. Did you practice in Vermont	during the past 12 months	?No
		n or license to practice:
16. States where you previously	were certified or licensed	to practice: VIRGINIA - 1986
17. Specialty:		DEA Number:
18. Name and office address of		
Name	Add	iress .
PPNNE		•
19. Please list (or use addition Physicians:		our current Primary and Secondary Supervising
Name, specialty and office ad	dress of Supervising Phy	ysician(s):
Name	Specialty	Address
Judy Tylon	oblegn_	PPNNE 183 TAKOH RD. WITHSton, VT. 0349
Cheryl Gibson	OBIGHN	PANNE 23 mansfield Ave Burl, VT. 0540
20. Name, specialty and office Name	address of the Seconda Specialty	
Susan Smith	OBLEYN	MNUE 23 mansfield AKE. Burl, VT. 05461
	1	

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2000-2002 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE THREE OF SIX

- 21. Please attach a copy of your current NCCPA certificate.
- 22. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice (see attached definition) for your practice setting, paying attention to any additions or deletions in duties and procedures.
- a) Has there been a change in your scope of practice which has not been reviewed by the Board?

  Yes \_\_\_\_\_\_ Yes \_\_\_\_\_ No
- b) Please review, sign and date by PA and PRIMARY SUPERVISING PHYSICIAN your scope of practice. Please attach a copy of your signed scope of practice.
- 23. Documentation showing practice as a Physician's Assistant within the past twelve months: Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician's Assistant within the past twelve months.

An applicant for certification renewal who has not practiced as a Physician's Assistant for more than twelve months must submit a satisfactory evaluation by the Supervising Physician prior to renewal.

- 24. Continuing Medical Education (CME) requirements:
- a. NCCPA certified Physician's Assistants: Attach proof of recertification; this will serve as adequate proof of CME completion.
- b. For all others, enclosed please find an explanation of requirements and a logging form. If you have any questions, please address them in writing to Board Member Katherine A. Silta, PA-C at the Board's address.
- 25. All Physician's Assistants are required to have a Secondary Supervising Physician for their practice. We have enclosed a form to be returned to this office if you do not have a Secondary Supervising Physician on file with our office.

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2000-2002 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FOUR OF SIX

#### **SECTION II**

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

Important note regarding the following questions: "Yes" answers on past renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 2000-2002 period if the answer to any of the questions on the next two pages changes from "No" to "Yes".

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

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2000-2002 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FIVE OF SIX

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

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

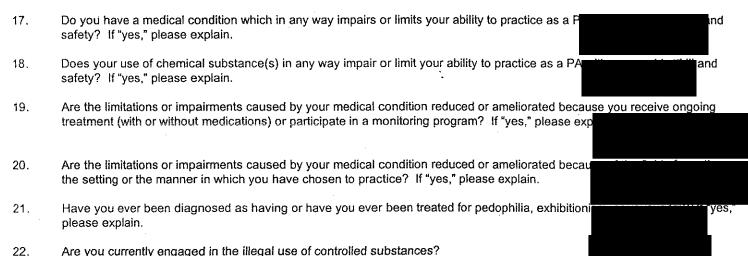
- The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
- 2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the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

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

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

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

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



- 22. Are you contently engaged in the megal use of controlled substances.
- 23. If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If "yes," p
- 24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, parar disorder?

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE - SECTION III 2000-2002 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION - PAGE SIX OF SIX STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS Applicant's Statement Regarding Child Support

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

or the lice 795)	nsing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. §
١.	You <u>must</u> check one of the two statements below regarding child support regardless whether or not you have children:
1	I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
	I hereby certify that I am <u>NOT</u> in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".  Applicant's Statement Regarding Taxes
renewed in taxes	3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A.
2	You <u>must</u> check one of the two statements below:  I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
or busine services of pains and all consideration, and contribution contribution commiss	I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".  Applicant's Statement Regarding Unemployment Compensation Contributions  1378 requires that: No agency of the state shall grant, issue or renewal any license or other authority to conduct a trade ss (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the department of penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any outributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this a person is in good standing with respect to any and all contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of outributions are due and payable; (2) the liability for any contributions or payments in lieu of outributions or payments in intributions due and payable would impose an unreasonable hardship.  You must check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:  I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions or payments in lieu of 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 penal
	I hereby certify that I am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
Taxes and	osure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of the Department of Employment and Training, in the administration of tax laws, to identify individuals affected by such laws, and by the Office of Child Support.  STATEMENT OF APPLICANT
I certify the providing	hat the information stated by me in this application is true and accurate to the best of my knowledge. I understand that false information or omission of information is unlawful and may jeopardize my license/certification/registration status.
	As D'A

#### **Planned Parenthood**

#### of Northern New England

Standing Orders for
Nurse Practitioners & Physician Assistants

The Family Planning Practitioner may:

Date Effective: December 1998

- A. Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.
- B. 1) Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol.
  - 2) Manage routine hormonal contraceptive and HRT problems.
  - Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.
- Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol.
  - 2) Manage routine Norplant problems.
- D. 1) Inject Medroxyprogesterone acetate (Depo-provera) in accordance with PPNNE Medical Protocol.
  - Manage routine DMPA problems.
- Insert and remove IUD's in accordance with the PPNNE Medical Protocol.
  - 2) Manage routine IUD problems.
  - 3) Order X-rays and sonograms for IUD localization.
- F. 1) Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol.
  - 2) Manage diaphragm and cervical cap problems.
- G. 1) Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol.
  - 2) Manage condom and spermicide problems.
- H. Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical mucus and calendar.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
- J. Administer parenteral medications in accordance with the PPNNE Medical Protocol. These medications specifically are:

Atropine

Cefoxitin

Ceftriaxone

Diphenhydramine (Benadryl) Dipheria, Tetanus vaccine

Diphtheria, Tetanus, Pertussis vaccine

Epinephrine

Gentamicin

Hepatitis B vaccine

Influenza vaccine

Lidocaine

Measies, Mumps, Rubella vaccine

Medroxyprogesterone acetate (Depo-provera)

Methylergonovine maleate (Methergine)

Penicillin

Pitocin

Pneumococcus vaccine

Progesterone

Rh immune globulin

Spectinomycin

Streptomycin

Tigan

Tuberculin skin test

Vancomycin

The following parenteral medications may be administered under

physician orders: Diazepam (Valium)

Phenobarbital

Other Emergency Drugs

K. Order and dispense the following oral medications in accordance with PPNNE Medical Protocol:

Acetaminophen (Tylenol)

Acyclovir (Zovirax)

Amoxicillin

Ampicillin

A.S.A.

Azithromycin

Cefixime

Ciprofloxacin

Clindamycin

Conjugated estrogens (Premarin)

Diphenhydramine (Benadryl)

Doxycycline

Mefenamic acid (Ponstel)

Methylergonovine maleate (Methergine)

Metronidazole (Flagyl)

Naproxen sodium (Anaprox)

Nicorette gum

Nordette (for MAP only)

Norfloxacin

Nystatin

Ofloxacin

Ovral (for MAP only)

Probenecid

Pyridium

Erythromycin
Estradiol (Estrace)
Fenoprofen (Nalfon)
Ferrous Furnarate
Ferrous Gluconate
Ferrous Sulfate
Fluconazole
Ibuprofen (Motrin, Nuprin, Advil)
Ipecac syrup
Ketoconazole

Macrodantin
Medroxyprogesterone acetate (Depo-provera)

Pyridoxine (Vitamin B6) Sulfizoxazole (Gantrisin) Tetracycline

Trimethoprim-sulfamethoxazole

(Bactrim, Septra)

Trivalent oral polio virus (TOPV)

Zyban

And, all oral contraceptives currently stocked by PPNNE.

The following oral medications may be administered under

physician orders: Diazepam (Valium) Oxazepam (Serax)

L. Order, dispense and use the following topical medications/suppositories in accordance with the PPNNE Medical Protocol:

Acigel

Ketorolac

Acyclovir cream (Zovirax)

Ammonia inhalant

Betadine vaginal preparations

Butoconazole nitrate cream 2%

(Femstat)

Clindamycin vaginal cream

Cleocin Vaginal Cream

Clotrimazole cream, suppositories

(Mycelex, Gyne-Lotrimin)
Condylox topical solution
Conjugated Estrogen Cream

Crotamiton cream/lotion (Eurax)

Dienestrol Cream Denavir Cream Estradiol Cream

Dimethyl Ether (Histofreeze)

Estrogen patches

Femizol-M cream, suppositories

Gentian violet Lugol's Solution

Metronidazole vaginal gel (MetroGel)

Misoprostol

Monsell's solution (Ferric subsulfate)

Nicotine patches

Nystatin suppositories, tablets

Permethrin (Elimite 5%)

Podophyllin (various formulations)

Synthetic pyrethrins (A-200, RID)

Terconazole vaginal creams, suppositories (Terazol)

Transdermal Nicotine Systems

Trichloroacetic acid

Trimethobenzamide (Tigan) Suppositories

Triple Sulfa creams, suppositories (Sultrin)

Xylocaine gel, ointment

- M. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
- N. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms.
- O. Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
- P. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.
- Q. Perform venipuncture; start and maintain I.V.'s.
- R. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- S. Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

The Family Planning Practitioner must:

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

I agree to practice under the above standing orders

2 CHUZ.S.

Signature /

Date

Collaborating Physician:
Judith Tyson, MD, Medical Director, PPNNE

11/98 ec

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

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

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

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

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

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

As specified in Section I, page 16 of the PPNNE <u>Medical Protocol</u>, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

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

Physician's Assistant:	Date:
Medical Director:	Date: 1/13/2 co c
Associate Medical Director:	Date:
Susan Smith, M.D. (Secondary Superv	vising Physician): Date: $\frac{1/(9/\varpi)}{}$



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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

January 10, 2000

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

Dear Friends:

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

Amy Borgman

In addition, the Physician's Assistants named above will be authorized to prescribe medications in accordance with the Scope of Practice submitted to and approved by the Vermont Board of Medical Practice. Practitioners at Planned Parenthood of Northern New England do not independently prescribe or dispense controlled drugs and therefore are not required to obtain an identification number from the federal Drug Enforcement Agency (DEA).

Sincerely

Judith Tyson, M.D. Medical Director



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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

#### MEDICAL OVERSIGHT AT PPNNE

#### Physician Oversight

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol and are approved by the Medical Director before functioning in an independent capacity. As part of a new practitioner's orientation, a "Practitioner Skills Assessment" checklist is completed. If further training in any expected area of competence is needed, this is arranged.

The Medical Director and Associate Medical Director provide oversight and supervision through on-site visits and consultations, telephone consultations, and quarterly in-services. They are available for telephone back-up on a 24-hour basis. In addition, the Medical Director works with the Affiliate Medical Committee, the Medical Management Team and the Director of Quality Assurance to develop and review protocols and audits and to evaluate any new developments in the medical field that may affect PPNNE. All PPNNE mid-level practitioners practice under standing orders developed by the Medical Director and approved by our Medical Committee. Practitioners attend quarterly continuing education in-service for medical training and discussion of protocol questions and other practice concerns.

We also have on staff a full-time Associate Medical Director, who is also a board certified OB/GYN. She is also available for consultation on a daily basis and to serve as Acting Medical Director when the Medical Director is on vacation or out of town. Both the Medical Director and Associate Medical Director visit sites on a regular basis for chart review and evaluation of patients with problems. In addition, we also have community physicians who are available to our staff for consultation, telephone back-up and periodic review of charts.

#### Affiliate Medical Committee

The Affiliate Medical Committee, comprised of physicians and allied health providers from Maine, New Hampshire, and Vermont, meets as needed, and is charged with assuring that the medical protocol under which PPNNE operates meets community standards and is in compliance with Planned Parenthood Federation of America (PPFA) national standards and guidelines. It is responsible for approving the protocols for any new medical service PPNNE undertakes, and for reviewing and recommending PPNNE's participation in any research project.

#### Practice Protocols

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

#### Medical Management Team

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

#### Director of Quality Assurance

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

#### 1. Quality Assurance Site Audit

The Director of Quality Assurance conducts an annual on-site evaluation of each clinic. This audit includes a comprehensive review of charts, laboratory and pharmacy logs and practitioner performance, as well as an evaluation of the safety of the clinic.

#### 2. Medical Record and Patient Care Audits

Medical Record and Patient Care Audits are conducted three times each year. The specific audit topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topic include: follow-up of abnormal Pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

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

# NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

Be it known that

# Amy S. Borgman

has successfully completed all requirements to achieve or maintain NCCPA certification, and may therefore use the designations

Physician Assistant-Certified and PA-C

Certificate Number: 1011373

Issue Date:

November 19, 1999

Expiration Date:

June 1, 2001

NATIONA, orcian assi

#### PLANNED PARENTHOOD

of Northern New England

FROM:

183 Talcott Road, Suite 101 Williston, Vermont 05495-2075

PPNNE CENTRAL O. >>> VT.Medical Board

Phone No. (802) 878-7232 Fax No. (802) 878-8001

PHONE #:

Number of pages (including cover page)

RE.

STATEMENT OF CONFIDENTIALITY

This facsimile transmittal sheet, and any documents that may be transmitted with it, may contain information which is confidential and/or priv and is intended solely for the use of the addressee, then any disclosure, photocopying, distribution or other use of the contents of this faxed information is prohibited. If you receive this facsimile in error, please notify us by telephone immediately, and arrangements will be made for retrieval of the original documents at no cost to you.

PPNNE Form 106Z 07/98 ec

## State of Vermont Board of Medical Practice

## Professional Certificate

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

Amy S. Borgman, PA-C
P.A. Certification Number: 55-0030098
Valid only while working under the supervision of Judith Tyson,
M.D.; Cheryl Gibson, M.D. and Susan Smith, M.D. at Planned
Parenthood of Northern New England, 90 Washington Street, Barre,

Valid through January 31, 2000.

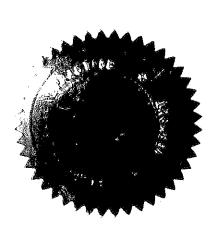
IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the

#### Vermont Board of Medical Practice

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

this	30th	day of	January	, A.D.,	19 <sup>98</sup>
. (		× ,	€ (	Penn	

Administrative Assistant



Processed 1-1202

# PA CHECK SHEET 2002-2004 RENEWAL

Name_	Anux	Borgman
Cerifica	ition#	055.07530098
Date Re	ceived_	1-22-02

<u> </u>
NA
_

Fee 75,00

**Application Pages Complete** 

Form A

NCCPA Proof of CME

Scope of Practice (Sign and Date -- PA and Primary)

Letter from Primary Supervisor attesting to practice within past 12 months

Primary Supervisor Form

Secondary Supervisor Form

See Rule 5.3 and 5.5. The Board is requiring updates on these forms during this renewal cycle. This is the classic situation where the greatest number of PA's are in compliance with the requirements of updating the Board on changes in supervisor, but the few who have not, make it necessary that everyone submit the updates to guarantee the files are complete.

Survey

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2002-2004 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PAGE ONE OF SIX

I hereby apply for the RENEWAL of my CERTIFICATION AS A PHYSICIAN ASSISTANT for the period from 02/01/02 to 01/31/04. TWO YEAR RENEWAL FEE: \$75.00 with each additional renewal \$50.00 Enclose a check in the proper amount made payable to the Vermont Board of Medical Practice.

**************************************
Important:
Please print legibly or type.
Answer all questions (front and back of each page) completely-it is rot adequate to state that the Board
already has the information. Use the enclosed Form A to provide explanations to "yes" answer
Section II.  Make a copy of this form and all attachments for your own records.
Do not delegate this important task, as false statements on this form are grounds for unprofessional
conduct.
Note: Physician Assistants 80 years of age or older are exempt from payment of a renewal fee; however, the
Physician Assistant certification renewal application must still be completed and submitted.
SECTION I
1. Name: Amy S. BORGMN JAN 2 2 2002
1. Name. 1000
2. Vermont Certification Number: 055- 0030098
3. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:
4. Home Address.
4. Home Address:
City, State, Zip Code: _
5. Office Address:) 90 WASHINGTON ST.
City, State, Zip Code: 13 are VT 05641
NOTE, CIDCLE VOLD BREEDBER MAILING ADDRESS THE ALL THE AREA
NOTE: CIRCLE YOUR PREFERRED MAILING ADDRESS. This address will be public and listed on the Board's web site.
6. Daytime Telephone Number: Area Code: (802) 476-696
o. Daylino Telephone Namori. The body ( 5 )
7. Date of Birth: Month: Day Year
8. Place of Birth:
9. Certification Examination Taken - Check:
NCCDA
NCCPA State Evamination Identity State
State Examination-Identity State: Other Examination Specify:
Other Examination Specify.
10. Basis for Vermont Certification: Apprenticeship Trained
University Trained

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2002-2004 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION PAGE TWO OF SIX

11. Do you have hospital privileges in Vermont? Yes No
Hospital Name(s) and Location(s):
12. Did you practice in Vermont during the past 12 months? Yes No
12. Did you practice in vermont during the past 12 months?  Yes No
13. Other states where you now hold an active certification or license to practice:
14. States where you previously were certified or licensed to practice:
15. Specialty: DEA Number:
16. Name and office address of current EMPLOYER:
Name Planned Parenthard & Northern 183 TALCOTT PD #101 17 Plans list (arms additional de tris)  New England WILLISTON VT 05495
17. Please list (or use additional sheet if necessary) your current PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).
Primary Supervising Physician(s):
Name Chenyl Gibson 23 Mansfield ave. Burly 17.05482.
Secondary Supervising Physician(s):
Name Susan Smith 23 Mansfield Ave. Burl, VT. 05482
18. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice (see attached definition) for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, sign and date by PA and PRIMARY SUPERVISING PHYSICIAN your scope of practice. Please attach a copy of your signed scope of practice.  a) Has there been a change in your scope of practice which has not been reviewed by the Board?  Yes

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2002-2004 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION PAGE THREE OF SIX

19. Documentation showing practice as a Physician Assistant within the past twelve months: Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

An applicant for certification renewal who has not practiced as a Physician Assistant for more than twelve months must submit a satisfactory evaluation by the Supervising Physician prior to renewal.

- 20. Continuing Medical Education (CME) requirements:
- a. NCCPA certified Physician Assistant: Attach proof of recertification; this will serve as adequate proof of CME completion.
- b. For all others, enclosed please find an explanation of requirements and a logging form.
- 21. Primary Supervising Physician and Second Supervisory Physician forms are enclosed to be completed and returned with this application.

## STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2002-2004 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PAGE FOUR OF SIX

#### SECTION II

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

Important note regarding the following questions: "Yes" answers on past renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 2002-2004 period if the answer to any of the questions on the next two pages changes from "No" to "Yes."

#### DURING THE PAST TWO YEARS.

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

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 2002-2004 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PAGE FIVE OF SIX

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

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

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

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

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

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

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

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







#### STATE OF VERMONT - OFFICE OF PROFESSIONAL REGULATION APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

#### PAGE SIX OF SIX

Regarding Child Support

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

1.	You must check one of the two statements below regarding child support regardless whether or not you have children:
	I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
	or
	I hereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".  Regarding Taxes
orandine v	3113 requires that; A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good with the Department of Taxes."Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the ioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You must check one of the two statements below regarding taxes:
	I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	or
	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".
	Regarding Unemployment Compensation Contributions
to, or ent declaration payments payments	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 ter 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 on, 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 of 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 of in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions are due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency find tring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.
3.	You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions
	I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contribution to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison a \$10,000.00 fine or both.)
	I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions du
	to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
	I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.
Social S	Date of Birth _
* The d	isclosure 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 ment of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such that Corner of Child Support

laws, and by the Office of Child Support.

#### STATEMENT OF APPLICANT

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

Signature of Applicant	1 2	1 Pre	Date	***
orginatore or representation				
	OFFICE OF THE SECRETA	RY OF STATE	-OFFICE OF PROFESSIONAL REGU	LATION

# The National Commission on Certification of Physician Assistants

hereby affirms that

# Amy S. Borgman

has successfully completed all certification requirements and earned the right to use the Physician Assistant-Certified designation.



L. Kathryn Hill, MEd, Executive Director

G.E. Winchester, MD, Secretary

Certificate Number: 1011373

**Issue Date:** 

June 6, 2001

**Expiration Date:** 

December 31, 2003

# of Northern New England

The Family Planning Practitioner may:

- Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common A. gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.
- Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol. В. 1)

2) Manage routine hormonal contraceptive and HRT problems.

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

Manage routine Norplant problems.

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

2) Manage routine DMPA problems.

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

2) Manage routine IUD problems.

- 3) Order X-rays and sonograms for IUD localization.
- Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol. F. 1)

2) Manage diaphragm and cervical cap problems.

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

2) Manage condom and spermicide problems.

- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical Η.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and 1. other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical
- Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws. J.
- Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol. K.
- Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms. L.
- Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child M. and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
- Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up N. routine and problem patients in accordance with the PPNNE Medical Protocol.
- О. Perform venipuncture; start and maintain I.V.'s.
- Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Ρ. Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and Q. especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

The Family Planning Practitioner must:

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

I agree to practice under the above standing orders

MA leve

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

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

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

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

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

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

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

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

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

Physician's Assistant

MAIN

Medical Director

tal Director L

Cheryl Gibson

Susan Smith, M.D.

Secondary Supervising Physician



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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

January 14, 2002

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

To Whom It May Concern:

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

#### ♦ Amy Borgman

In addition, the Physician's Assistant named above will be authorized to prescribe medications in accordance with the Scope of Practice submitted to and approved by the Vermont Board of Medical Practice. Practitioners at Planned Parenthood of Northern New England do not independently prescribe or dispense controlled drugs and therefore are not required to obtain an identification number from the federal Drug Enforcement Agency (DEA).

Sincerely,

Cheryl Gibson Medical Director



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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

#### MEDICAL OVERSIGHT AT PPNNE

## Physician Oversight

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

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

#### **Practice Protocols**

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

#### Medical Management Team

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

#### Director of Clinical Quality Improvement

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

#### 1. Quality Assurance Site Audit

The Director of Clinical Quality Improvement conducts an extensive annual on-site evaluation of each clinic. The audit includes a comprehensive review of charts, laboratory and pharmacy logs and practitioner performance, as well as an evaluation of the safety of the clinic.

#### 2. Medical Record and Patient Care Audits

Medical Record and Patient Care Audits are conducted three times each year. The specific topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topics include: follow-up of abnormal pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

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

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

A STATE

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete application	ns will be returned. Attach	additional sheets as needed.
Name in full	Gibson	Chery	A.
	(Last)	(First)	(Middle)
Mailing Address	Planned	Parenthood.	
	23 Mans	4	
	Burlingt	ON, VT. 05401	(802) 863-6326
(City/State)		(Zip Code)	(Telephone Number)
Vermont License #:	042-0074	465	
Hospital(s) where y	ou have privileg	es: Hospital(s) tanny Allen Purl	Location Specialty NT. OBIGN
What arrangements	have you made wo other P.P	for supervision when you as M.DS: SUSan Smv	re not available or out of town: thand balyn thouas
	CERTIFICA	TE OF SUPERVISING P	HYSICIAN
of Amy Gorgmon outlining the scope of p	ractice, attached to	, P.A. while under my supervisio this application, does not exceed	ally responsible for all medical activities n. I further certify that the protocol the normal limits of my practice. I in accordance with 26 VSA, Chapter 31,
	ive read the statutes	X Car	idian's assistants.  Le of Supervising Physician)
		Co-signature of PA:	Baguer
Note: A PA who prescri	bes controlled drug	s must obtain an ID number fron	n DEA. PA'S DEA Number NA

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

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	emplete application	is will be returned. Attach	additional sheets as nee	eded.
Name in full	Smith	Susan	Fa	.4
	(Last)	(First)	(Mi	ddle)
Mailing Address	Planned	Parenthood (Office Name)		
	23 Man	sfield are.		
		(Street) (OV, VT. OSTO) (Zip Code)	(802) 863-633	
(City/State	e) J	(Zip Code)	(Telephone Number	er)
Vermont License	#: <u>042-000</u> 9	5990		
Hospital(s) where Hetcher Allen	you have privilego	es: Hospital(s	) Location Spe UrL. VT OB	cialty 1640
Amy Borgman -	P.P Barry, VT P.P Hude PK., VT	and addresses you current Joanne Gutt P.P.Der Johanna Hauser P.P. F Katra Kindar P.P.	14, VT. Cate Nichola:	PP BUYL
CEI	RTIFICATE OF S	SECONDARY SUPERVI		<i>)</i>
of Amy Boro only when consulted practice, attached to t 26 VSA, Chapter 31,	by the aforesaid Physi his application, does n Section 1741, the use	VSA, Chapter 31, I shall be leg P.A. only when the primary su cian's Assistant. I further certif tot exceed the normal limits of r of a physician's assistant has be	pervising physician is unava y that the protocol outlining ny practice and that in accor en posted.	ilable and the scope of
(Date)	nave read the statutes	and Board rules governing phy (Signature of Sec	sician's assistants.  LULLUMU  condary Supervising Physici	an)

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

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

TWO YEAR RENEWAL FEE: \$75.00 for first certification; \$50.00 for each additional certification Please enclose a check in the proper amount made payable to the Vermont Board of Medical Practice.

Note: Physician Assistants 80 years of age or older are exempt from payment of a renewal fee; however, the Physician Assistant certification renewal application must still be completed and submitted.

#### Important:

- Please print legibly or type.
- Answer all questions completely -- it is not adequate to state that the Board already has the information. Use Form A to provide explanations to "yes" answers in Parts II and III.
- When space is insufficient, attach additional sheets.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task, as false statements on this form are grounds for findings of unprofessional conduct.
- Be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.
- Please return the document in its entirely at your earliest convenience. Your current certificate expires on January 30, 2004.

	PART I
1. Name: Amy S. Borgman	
2. Gender:   Male Female	DEGELVEN
3. Vermont Certification Number: 055-003	0098 JAN 2 8 2004
4. Other Name(s), if any, under which you	were certified or licensed in Vermont and elsewhere:  VERMONT BOARD OF MENCAL PROCESS
5. Home Address:	t mattered the state and a fill the second account to the second a
City, State, Zip Code:	
6. Work Address:	PPNNE 90 WASHINGTON ST BARRE UT 05641
Please check your preferred mailing address (This address	s:   Home  Work  will be public and listed on the Board's website)
7. Email Address	
8. Daytime Telephone Number: Area Code:	(802) 476.6696
9. Date of Birth (Month/Day/Year):	
10. Place of Birth: _	
Vermont Department of Health-Board	of Medical Practice-2004-2006 Physician Assistant Certification Renewal

11. Certification	Examination Taken – (	Check box and enter date of examination):
□ <u>(3</u>	/16/01) NC	CAA Cort. issued 6/6/01.
	//) Stat	te Examination-Identity by state:
<u> </u>	//) Oth	er Examination specify:
12. Basis for Ver	mont Certification – (C	Check box):
	prenticeship Trained versity Trained	
13. Do you have l	hospital privileges in \	Vermont? □ Yes ⊡No
Hospital Name(s)	and Location(s):	
14. In what year c	lid you start working a	is a physician assistant in Vermont?( N 86
15. Did you pract	ice in Vermont during	the past 12 months?    ✓ Yes □ No
An applicant for a must submit a sat	certification renewal v isfactory evaluation b	who has not practiced as a Physician Assistant for more than twelve months y the Supervising Physician.
16. Other states w	here you now hold an	active certification or license to practice:
		ertified or licensed to practice: VIFGINIA
		DEA Number: MB 0763234
19. Name and offi	ce address of current I	EMPLOYER:
Name		Address
Planned Pa	renthood	90 washington st. barre, VT. OSWII
20. Please indicate currently serve as	the total number and your <b>PRIMARY</b> and	list (use additional sheet if necessary) name(s) and address(es) of physicians whe SECONDARY SUPERVISING PHYSICIAN(S).
Total number	)	
Primary Supervisi	ng Physician(s):	
Name: Cheryl A.	. Gibson	
	field Avenue on, VT 5401	
Name		Address

Secondary Supervising Physician(s):		
Name Susan Smith Address 33 M	Janufield Alle. Burl.	VT. 0240
Kym Bayman		Management
21. Scope of Practice: The Board of Medical Practice requires review the most current scope of practice for your practic duties and procedures. Please review, date and sign your SUPERVISING PHYSICIAN sign it as well. Attach a	ce setting, paying attention to any addition scope of practice and have your PDIM	ons or deletions in
a. Has there been a change in your scope of practice which	ch has not been reviewed by the Board?	□ Yes 🏿 No
22. Please provide a letter from your Supervising Physician at Assistant within the past twelve months.	ttesting to the fact that you have practice	ed as a Physician
23. Continuing Medical Education (CME) requirements:		
<ul> <li>a. NCCPA certified Physician Assistant: Attach proof of proof of CME completion.</li> </ul>	f current NCCPA certification; this will	serve as adequate
b. For all others, an explanation of requirements and a lo	gging form must be completed.	
<ol> <li>Primary Supervising Physician and Second Supervisory Pl returned with this application.</li> </ol>	hysician forms are provided. They must	be completed and
PART	ГИ	
"Yes" answers to Questions 25 - 39 require an explanation	on Form A.	٠.
Important note regarding the following questions: "Yes" answ example, if a previously reported malpractice action has been	ers on past renewals must be updated or dismissed, please indicate that on Form	n Form A. For A.
Any "yes" response to the questions below must be fully en	xplained on Form A.	
Certification and Practice Questions		
25. Have you ever applied for and been denied a license or ce other healing art?	ertificate to practice medicine or any	□ Yes ☑ No
26. Have you ever withdrawn an application for a license or c other healing art?	ertificate to practice medicine or any	□ Yes ☑ No
27. Have you ever voluntarily surrendered or resigned a licensary other healing art in lieu of disciplinary action?	se or certificate to practice medicine or	□ Yes ☑ No
28. Are any formal disciplinary charges pending or has any di against you by any governmental authority, by any hospita professional medical association (international, national, s	il or health care facility, or by any	□ Yes ☑ No
29. Have you ever been denied the privilege of taking an examining board?	nination before any state medical	□ Yes ☑ No
30. Have you ever discontinued your education, training, or pr months, for reasons other than a family situation?	ractice for a period of more than three	□ Yes ☑ No
31. Have you ever been dismissed or suspended from, or asked before completion?	d to leave a residency training program	□ Yes 🗖 No

32. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?	□ Yes ☑ No
33. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?	□ Yes ☑ No
34. Are you presently a defendant in a criminal proceeding?	□ Yes ☑ No
PART III	
Confidential Section (This section is exempt from public disclosure) Any "yes" response to the questions below must be fully explained on Form A.	
35. To your knowledge, are you the subject of an investigation by any other licensing or certification authority as of the date of this application?	
36. To your knowledge, are you presently the subject of criminal investigation?	

#### MEDICAL QUESTIONS

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

#### **DEFINITIONS**

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

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

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



38. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety? In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.



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

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



**IMPORTANT** 

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

#### Part IV - Statutory Profile Questions

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

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

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

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

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

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

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

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

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

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

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

# 43. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]

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

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

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

#### A. Revocation/Involuntary Restrictions

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

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

	related to comp documenting	petence or cha	iracter in that ho	n in lieu of, or in settlem spital. Please provide c	opies of papers f	ully
	(Date)			(Hospital)		(State)
	(Nature of Act	ion)		(Action)	,	
	(Reason for Ac	otion)		□ In lieu	☐ In settlemer	nt
	(Reason for Ac	tuon)	·			
		udgments/Set	tlements [See 2	6 VSA § 1368(a)(6A)]		
А. <u>Ј</u>	udgments					
	maipractice art	otration award	is against you in	alpractice court judgmer which a payment was av menting these matters.	nts against you an warded to a comp	d all medic laining part
	□ Judgement	□ Arbitrat	ion			
	(Date)	(Court)	(State) (1	Nature of Case) (Amo	unt Assessed Aga	inst You)
	☐ Judgement	□ Arbitrat	ion			
	(Date)	(Court)	(State) (I	Nature of Case) (Amo	unt Assessed Aga	inst You)
B. <u>S</u>	ettlements					·
	Please provide payment was av these matters.	a description warded to a co	of all settlements	s of medical malpractice  Please provide copies	claims against yo of papers fully o	u in which locumentii
	(Date)	(Court)	(State)	(Amount of Set	tlement Against \	(ou)
	(Date)	(Court)	(State)	(Amount of Set	tlement Against Y	You)

46.

47.	granting pe	ents/Teaching [See rmission to have thing appoints are teaching appoints	s information po:	sted on the	lote: Answering #35 is optional. web. (This form follows the stanay overlap.)	By answering, you are atutory wording. Since most
	A.	Appointments				
		Please provide in	formation about	your appo	intments to medical school or pr	ofessional school faculties.
		(School)	(City)	(State)	(Nature of Appointment) From	n (year) To (year)
		(School)	(City)	(State)	(Nature of Appointment) From	n (year) To (year)
	В.	Teaching				
		Please provide inf within the past 10	ormation regardi years.	ing your re	esponsibility for teaching gradua	te medical education
		(School/Institution	ı) (City)	(Sta	te) (Nature of Teaching)	From (year) To (year)
	the web	years.	formation regard	ing your p	are granting permission to have to bublications in peer-reviewed me	edical literature within the (Year)
				`	,	(Icai)
	(Title	e)		(Publica	tion)	(Year)
49.	<u>Activiti</u>	es [See 26 VSA §	1368(a)(14)]			
	Note: A	answering #52 is op Please provide in	ormation regard	ring, you a ing your p ies or Awa	re granting permission to have to rofessional or community service ards)	this information posted on the activities and awards.
	50. <u>Pra</u>	ctice Setting [See 2	26 VSA § 1368(a	)(15)]		·
	What is	the location of you	r primary practic	e setting?		
	90	WASHINGTON	\$ 12	James	- VT 05641	
	Town/C	City, State				
51.	Translating	Services [See 26 V	SA § 1368(a)(16	)]	•	

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

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Are a	my translating services available at your pr	rimary practice	location?	
	s, please describe the translating services a			
				·
				·
52. Medicaid/	New Patients [See 26 VSA § 1368(a)(17)	)] .		
A.	Medicaid participation  Do you participate in the Medicaid pro	ogram?	<b>☑</b> Yes □ No	
В	New Medicaid Patients			
	Are you currently accepting new Medi	caid patients?	☑Yes □ No	
		Part V		
Are you curren	ntly active in clinical practice in Vermont?		☑Yes □ No	
If you do not p	rovide patient care in Vermont, skip the re	est of Part V and	d go to Part VI	
Please select th	e location(s) in Vermont related to this cerue specialty codes from the list provided (I	ink), and enter :	the average hours per week you	spend providing
site. Please exc	ENT CARE. Include both AMBULATOR clude on-call hours.	CY care and HC	OSPITAL care of patients who o	riginate from this
Enter the Verm	nont town name for this location: <u>Ba</u>	rre ot	Non.	
Select the ONE	E practice setting that best describes this pre e hospital care to patients who originate fr	ractice:		g from which they
☐ School or 6 ☐ Business o	y-Based practice (including associated hor ased practice (Inpatient, Emergency Roon College Health Center r Work Site Care / Nursing Home	spital care - solo 1, etc)	o or group office, Community H	lealth Center, etc.)
I work as a locu	ım tenens here □Yes ZNo			
If this is an offi	ce-based practice, please answer the follo	wing:		
I currently have I will accept ne I will accept ne	e patients here covered by Medicaid e patients here covered by Medicare w patients here w Medicaid patients here w Medicare patients here	Yes ONo Yes ONo Yes ONo Yes ONo Yes ONo		
Enter the number (48 weeks is co	er of weeks you spend providing direct pansidered to be "full time") 50 [2 digits]	tient care here i	in a year:	

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Enter your specialty and the number of hours you spend average work week:	providing direct patient care here under that specialty in an
First Specialty: (101 [4 digits] (see attached list or lin	k) Hours per week: 13 [2 digits]
Second Specialty: [4 digits] (see attached list or	link) Hours per week: [2 digits]
Do you plan to retire or reduce your patient care hours A	T THIS SITE in the next 12 months? ☐Yes ☑No
If you work at another location or setting UNDER THE you work only at one site under this certificate please sto another site under a different certificate, please describe certificate, not here.)	SAME CERTIFICATE please answer the questions below. If p here, leave Part V blank, and skip to Part VI. (If you work at your work at that site in the renewal form for that other
Enter the Vermont town name for the second location:	RANDOCPH
Select the ONE practice setting that best describes this provide hospital care to patients who originate from the originate.)	ractice: om your office or clinic, choose only the setting from which the
Community-Based practice (including associated ho Hospital-based practice (Inpatient, Emergency Roon School or College Health Center Business or Work Site Extended Care / Nursing Home Other:	spital care - solo or group office, Community Health Center, etc n, etc)
I work as a locum tenens here Yes No	
If this is an office-based practice, please answer the follo	wing:
I currently have patients here covered by Medicaid I currently have patients here covered by Medicare I will accept new patients here I will accept new Medicaid patients here I will accept new Medicare patients here	<ul> <li>         □Yes □No         □         □         □</li></ul>
Enter the number of weeks you spend providing direct pa (48 weeks is considered to be "full time") 50 [2 digits	itient care here in a year:
Enter your specialty and the number of hours you spend paverage work week:	providing direct patient care here under that specialty in an
First Specialty: 100 [4 digits] (see attached list or link	c) Hours per week: 6 [2 digits]
Second Specialty: [4 digits] (see attached list or l	ink) Hours per week: [2 digits]
Do you plan to retire or reduce your patient care hours A	T THIS SITE in the next 12 months? □Yes ☑No
If you work at more than two locations UNDER THE SA briefly, e.g., "same specialty and hours in additional town	ME CERTIFICATE please describe the additional site(s) as: X and Y":
1	The state of the s

#### Part VI

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

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

Date: 12 16 53

Applicant's Signature

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

# Vermont Department of Health - Board of Medical Practice

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

You <u>must</u> answer	questions	1, 2,	and	3.
------------------------	-----------	-------	-----	----

pay any and all child support due under that order.

1.

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)

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

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

		I hereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".
Title 32	§ 311	Regarding Taxes  3 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the est that he or she is in good standing with the Department of Taxes 1/5 and at 1/5 a
on appe	al, the	es that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is a taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that yment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You	must check one of the two statements below regarding taxes:
	, D	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).
		horshy contifue that I am NOT's man I ( )
	<b></b> J	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".
Titla 21 8	: 1379	Regarding Unemployment Compensation Contributions
		3 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business cense to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate
contribu	tions	y employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the it 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 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 any or payments in lieu of contributions payments in lieu of contributions payments in lieu of contributions payments.
he liabil payment	ity fo plan	ons or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) rany contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions n lieu of contributions due and payable would impose an unreasonable hardship.
3. contribu		
	a	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)
		I hereby certify that I am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
		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 Se	curit	Date of Birth
		re 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 nent of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals ch 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

12.16.03

false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Vermont Department of Health - Board of Medical Practice

Signature of Applicant

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

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

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	mplete applications will b	e returned. Attach additiona	l sheets as needed.
Name in full	Gibson	cheryl	Α
	(Last)	(First)	(Middle)
Mailing Address	Planned Pa	arenthood	
	23 mansti	(Office Name)	
	Burlingto	(Street)	863-6326
(City/State	c) (Zip C	ode) (Tele	ephone Number)
Vermont License	#: <u>042-0007</u> 465		
Hospital(s) where	you have privileges:	Hospital(s) Location	n Specialty
F.A.H.C	Rur	lington, vT. 0540	L OBLOWN.
	n CAII Service CK-UP Secondar	y specusing th	ysicians.
	CERTIFICATE OF	SUPERVISING PHYSICI	AN
of 14111 501 outlining the scope of	practice, attached to this applic	apter 31, I shall be legally responsite under my supervision. I furthe cation, does not exceed the normatian's assistant is used, in accordance	r certify that the protocol limits of my practice. I
I further certify that I	have read the statutes and Boar	d rules governing physician's assi	hus
	Co-sign	ature of PA: A SB	len
Note: A PA who pres	cribes controlled drugs must ob	otain an ID number from DEA. PA	A's DEA Number MB0763

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

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	aplete applications	will be returned	i. Attach add	itional sheets a	as needed	•
Name in full	Boyman	K	mui		m.	
	(Last)	(	First)	······································	(Middle	)
Mailing Address	Planned	Parentho	00			
	23 Man	stield AV	Name)			
	Burlingt	on VT.	540l	863-63	32b	TO A STATE OF THE
(City/State)		(Zip Code)		(Telephone N	umber)	
Vermont License #:	<u>049-0010</u> 2	97				
Hospital(s) where y	ou have privileges	:E	Iospital(s) Lo	cation	Specialty	<i>y</i>
F.A.H.C		Burlina	ton, vi	*	OB	6YN.
List all physician's a Amy Gorgman August Burns Sur Burton	-P.P Hyde Par	Johanna H	iauser-P.P Odox -P.P	Burlington	$\nabla \Delta \Delta$	May 4-
CERT	TFICATE OF SE	CONDARY SI	UPERVISIN	G PHYSICIA	.N	
hereby certify that, in a port of Amy Borger only when consulted by practice, attached to this VSA, Chapter 31, Section	the aforesaid Physicia application, does not	SA, Chapter 31, I si A. only when the p n's Assistant. I fur exceed the normal	hall be legally re orimary supervisi ther certify that	esponsible for all ing physician is unthe protocol outli	medical act navailable a	ınd
further certify that I have	ve read the statutes an	d Board rules gove	rning physician'	s assistants.		
(Date)		X = 1	1551-	`		
(Date)	- TO THOUGHT	(Signature of Se	condary Superv	ising Physician)		<del></del>

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

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.  Name in full Smith Susqn —  (Last) (First) (Middle)  Mailing Address Planned Parenthood  Attach additional sheets as needed.  (First) (Middle)  Mailing Address Planned Parenthood  (Office Name)  Burl, VT. OSHO 863-6326  (City/State) (Zip Code) (Telephone Number)
Mailing Address Planned Farenthood  33 Mansfield Ave.  Burl, VT. OSHO! 863-6326
Burl, VT. 05401 863-6326
Burl, VT. 05401 863-6326
BURL, VT: 05401 863-6326
(City/State) (Zip Code) (Telephone Number)
Vermont License #: <u>042-0005990</u>
Hospital(s) where you have privileges: Hospital(s) Location Specialty
F.A.H.C Burlington, VT. OB/GIN.
List all physician's assistants names and addresses you currently supervise:  Any Borgman - P.P BARRE Johanna Hauser - P.P Burlington Barb Nolfi - R  August Burns - P.P Hyde Park Katra Kindar - P.P Burlington Janet Young - P  Sue Burton - P.P Burlington Cate Nicholas - P.P Burlington Anne Hildrethe
CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN
I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Amus Comman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician's Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice andthat in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician's assistant has been posted.
further certify that I have read the statutes and Board rules governing physician's assistants.
(Signature of Secondary Supervising Physicians)

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

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

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

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

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

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

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

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PPNNE BARRE →→→ Central OFFICE ZIO FLANWED PARENTHOOD PAGE #3/#3

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

Physician's Assistant Soreman

1・20・0 9 Date

Cheryl Gibson

Primary Supervising Physician



SERVING MAINE. NEW HAMPSHIRE AND VERMONT

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

# MEDICAL OVERSIGHT AT PPNNE

## Physician Oversight

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

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

# **Practice Protocols**

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

#### Nurse Practitioners & Physician Assistants

of Northern New England

Family Planning Practitioner may:

Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.

- Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol. В. 1)
  - Manage routine hormonal contraceptive and HRT problems. 2)
  - Order special laboratory tests needed to prescribe hormonal contraceptives and HRT. 3)
- Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol. C. 1)
  - 2) Manage routine Norplant problems.
- Inject Medroxyprogesterone acetate (Depo-provera) in accordance with PPNNE Medical Protocol. 1) D.
  - 2) Manage routine DMPA problems.
  - Insert and remove IUD's in accordance with the PPNNE Medical Protocol. 1)
    - Manage routine IUD problems. 2)
    - 3) Order X-rays and sonograms for IUD localization.
  - Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol. 1)
    - Manage diaphragm and cervical cap problems. 2)
- Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol. 1) G.
  - Manage condom and spermicide problems. 2)
- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical 4 mucus and calendar.
  - Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
  - Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.
- Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
  - Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms.
  - Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
    - Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.

Perform venipuncture; start and maintain I.V.'s.

Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.

Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

#### a Family Planning Practitioner must:

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

ree to practice under the above standing orders

Ε.

F.

rature

Collaborating Physician: Cheryl Gibson, MD, Medical Director

VE Form 10HR 12/01mm



January 13, 2004

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

# To Whom It May Concern:

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

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

Sincerek

Cheryl Gibson

Medical Director

# The National Commission on Certification of Physician Assistants

hereby affirms that

# Amy S. Borgman

has successfully completed all certification requirements and earned the right to use the Physician Assistant-Certified designation.

WATION COMMISSION C

Gary E Winchester, MD, Chairman of the Board

Dorothy D. Pearson, PA-C. Secretary

Certificate Number: 1011373

Issue Date:

November 3, 2003

**Expiration Date:** 

**December 31, 2005** 

PO 75.00

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

# 2006 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

#### PARTI

Certificate # 055-0030098	PARTI		
1. Name: Amy S. Borgman P.	A-C		
2. Other Name(s), if any, und	ler which you were certified or licensed in Vermont an	d elsewhe	ere:
3. Home Address:			
4. Work Address: ٩٥	WASHINGTOD IT		
City, State, Zip Code:	RRE UT 05641		National Control of the Control of t
Please check your preferred (This	mailing address:   Home Work  address will be public and listed on the Board's websi	ite)	
5. Email Address			
6. Daytime Telephone Numbe	r: Area Code: ( <u>88</u> 2) 4 7 6 - 6 6 9 6		1
7. Date of Birth: Month:		12	5 . 2008
<ul><li>8. Place of Birth:</li><li>9. Certification Examination Ta</li></ul>	aken – (Check box and enter date of examination):		
= (3/16/200)i	NCCPA		
· (//)	State Examination-Identify state:		
	Other Examination specify:		
10. Basis for Vermont Certifica	ation – (Check box):		
□ Apprenticeship Tr  ✓ University Trained			
11. Do you have hospital privile Hospital Name(s) and Location	eges in Vermont? ☐ Yes,☑No n(s):		

12. In what year did yoւ	start working as a physician assistant in Vermont?
13. Did you practice in \	/ermont during the past 12 months? ☐ Yes ☐ No
14. Other states where	you now hold an active certification or license to practice:
15. States where you pr	eviously were certified or licensed to practice:
16. Specialty:	DEA Number:
	dress of current EMPLOYER:
Name	Address
18. Please list (use addit as your PRIMARY and S	tional sheet if necessary) name(s) and address(es) of physicians who currently serve SECONDARY SUPERVISING PHYSICIAN(S).
Primary Supervising Phy	rsician(s):
Name	Address
Secondary Supervising I	Physician(s):
Name	Address
additions or deletions	ne Board of Medical Practice requires that you and your primary supervising he most current scope of practice for your practice setting, paying attention to any in duties and procedures. Please review, date and sign your scope of practice and SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of eation.
a. Has there been a ∈	change in your scope of practice which has not been reviewed by the Board?
20. Please provide a lette Physician Assistant v	er from your Supervising Physician attesting to the fact that you have practiced as a vithin the past twelve months.

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

21. Continuing Medical Education (CME) requirements:

adequate proof of CME completion.

- b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

#### **PARTII**

"Yes" answers to Questions 23 - 46 require an explanation on Form A.

- 23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
- 24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

□ yes 🗷 no

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

□ yes 📈 no

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

□ yes øno

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

□ yes 🔀 no

28. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?

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

□ yes 🗷 no

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

□ yes 📈 no

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

□yes ⊿no

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

□ yes 💅 no

#### PART III

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

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

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

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



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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

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

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

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

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

#### **IMPORTANT**

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

# Part IV - Statutory Profile Questions

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

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

car	not process your applic	ation without them.		, , , , , , , , , , , , , , , , , , , ,
38.	Criminal Convictions [Se	e 26 VSA § 1368(a)(1)	] □ Check here if none	
	or parking lickets) of v	ription of all crimes (felo hich you have been co ation for each matter.	nvicted within the past 10 v	nis includes DUI but not speeding ears Please provide complete
	(Conviction Date)	(Court)	(City/State)	(Crime)
39.	Nolo Contendere/Matters	Continued [See 26 VS	SA § 1368(a)(2)] □ Che	eck here if none
	or where sufficient lac	is of quiit were found a	which you pleaded "nolo condition the matter was continuently the copies of documently the copies of the copies of documently the copies of docume	ontendere" ("I will not contest it" ed without a finding by a court o ntation for each matter.
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
40.	Vermont Board of Medical	Practice Matters [See	26 VSA § 1368(a)(3)]	☐ Check here if none
	Please provide a desc Board of Medical Prac appealed.	ription of all formal cha tice (including stipulatio	rges served, findings, conc ons), and final disposition o	clusions, and orders of the of such matters by the courts, if
	(Date)	(Fina	al Disposition - Summary)	
	(Date)	(Fina	al Disposition - Summary)	
	(Date)	(Fina	al Disposition - Summary)	

(Date)			(Hospital)			
(Nature of Action) □ In settlement (Reason for Action)		(Action)			***************************************	□ In lie
dical M	alpractice Court	Judgments/Se	ettlements [See	26 VSA § 1368	B(a)(6A)]	
A.	Judgments	⊠ Check he	re if none			
	Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years fi payment date) in which a payment was awarded to a complaining party if not listed below. Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.					
	□ Judgment	☐ Arbitration	١			
	(Date)	(Court)	(State) (Na	iture of Case)	(Amount Assesse	ed Against You)
	☐ Judgment	☐ Arbitration	ו			
	(Date)	(Court)	(State) (Na	ture of Case)	(Amount Assesse	ed Against You)
B.	Settlements		re if none			
	Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. Please provide complete copies of documentation, to include final disposition and, if possible a copy of the complaint for each matter.					
	(Date)	(Court)	(State)	(A	mount of Settlemer	t Against You)
	(Date)	(Court)	(State)	(A	mount of Settlemen	nt Against You)
rs of Pr	ractice [See 26	VSA § 1368(a	)(10)]		· · · · · · · · · · · · · · · · · · ·	
at mon	th and year did	you start pract	icing as a Physic	cian Assistant?	June 19	84
ointme	ents/Teaching to have this info	[See 26 VSA §	1368(a)(12)] N	ote: Answering	#48 is optional. By	answering, you are grantir

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character

in that hospital. Please provide complete copies of documentation for each matter.

43.

44.

45.

Vermont Department of Health – Board of Medical Practice – 2006-2008 Physician Assistant Certification Renewal Page 6 of 1

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

		☐ Judgment	☐ Arbitration				
		(Date)	(Court)	(State)	(Noture of Coss)	()	
		,	•	,	(Nature of Case)	(Amount Assessed Against \	(ou)
		☐ Judgment	☐ Arbitration				
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against \	/ou)
	B.	Settlements	□ Check here	e if none			ĺ
		complaining pass	arty if not listed	ears from below. <b>Pl</b> e	payment date) in wh ease provide comp	alpractice claims against you ich a payment was awarded to lete copies of documentation e complaint for each matter.	~
		(Date)	(Court)	(State)	(A)	mount of Settlement Against Y	ou)
		(Date)	(Court)	(State)	(A	mount of Settlement Against Y	ou)
	Appointm you are gr	nents/Teaching [ anting permission	See 26 VSA §	1368(a)(12 formation	nosted on the wah .	#48 is optional. By answering, This form follows the statutory estions may overlap.)	,
	A.	<u>Appointments</u>					
		Please provide faculties.	information abo	out your a	opointments to medi	cal school or professional scho	loc
		(School) (Cit	y) (Sta	te) (Nat	ure of Appointment)	From (year) To (year)	
		(School) (City	y) (Sta	te) (Nat	ure of Appointment)	From (year) To (year)	
	В.	<u>Teaching</u>					
		Please provide education withir	information reg n the past 10 ye	arding you ars.	r responsibility for te	eaching graduate medical	
	(Schoo	l/Institution)	(City)	(State)	(Nature of Teachin	g) From (year) To (yea	<del>ir)</del>
46.	Publica	ations [See 26 V	SA § 1368(a)(13	3)]	-		

·	Note: Answering #49 posted on the web. Fiterature within the pa	is optional. By answering, you are granting permi Please provide information regarding your publicat ast 10 years.	ssion to have this information tions in peer reviewed medica
	(Title)	(Publication)	(Year)
	(Title)	(Publication)	()/>
47.	Activities [See 26 VS.	•	(Year)
·	Note: Answering #50 i posted on the web. Plactivities and awards.	is optional. By answering, you are granting permis lease provide information regarding your profession	ssion to have this information onal or community service
e.		(Activities or Awards)	
48. <u>Pra</u>	actice Setting [See 26 \	√SA § 1368(a)(15)]	
		your primary practice setting?	
	Town/City, State		
49. <u>Tra</u>	nslating Services [See	26 VSA § 1368(a)(16)]	
	Please identify any tra	nslating services available at your primary practic vices available at your primary practice location?	e location. □ Yes □ No
		the translating services available:	
50 Med	dicaid/New Patients IS	ee 26 VSA § 1368(a)(17)]	
	A. <u>Medicaid partic</u>	· -	· 0
	B. <u>New Medicaid</u>		

#### Part V

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

Date: (1-19-05

Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

#### Regarding Child Support

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

1. You	must check one of the two statements below regarding child support regardless whether or not you have children:  I hereby certify that, as of the date of thisapplication: (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 dueunder 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 aunreasonable hardship. Please forward an "Application for Hardship".
	Regarding Taxes
eturns have	3 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the es that he or she is in good standing with the Department of Taxes."Good standing" means that no taxes are dueand payable and all been filed the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissionef Taxes, or authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
You	must check one of the two statements below regarding taxes:
	I hereby certify, under the pains and penaltis or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
	or
0	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose unreasonable hardship. Please forward an "Application for Hardship".
	Regarding Unemployment Compensation Contributions
fitle 21 § 137	B requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a tracter business
including a li	cense to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate
pace with an	y employing unit unless such employing unit shall first sign a written declaration under the nains and penalties of perium, that the
employing un contributions all contributions he liability fo payment plan	It 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 due as of the date such declaration is made. Fo the purposes of this section, a person is in good standing with respect to any and one or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment contributions.
r payments i	n lieu of contributions due and payable would impose an unreasonable hardship.
. You ontributions:	must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment
A	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)
	I hereby certify that I amNOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determinethat requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
	hereby certify that 21 V.S.A. § 1378 is not applicabl to me because I am not now, nor have I ever been, an employer.
ocial Securit	
ie Departmer	re of your social security number is mandatory, it is solicite <b>b</b> y the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by It of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected and by the Office ofChild 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 jeografize my license/certification/registration status.

Vermont Department of Health – Board of Medical Practice – 2006-2008 Physician Assistant Certification Renewal Page 19 of 19

# National Commission on Certification of Physician Assistants

hereby affirms that

# Amy S. Borgman

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

The valetimes Assistant Certifical

designation.

Certificate Number: 1011373

Dorothy D. Pearson, PAC, Chairman of the Board

Effective On: November 7, 2005



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

## 2006-2008 PHYSICIANS ASSISTANT CERTIFICATION RENEWAL APPLICATION CONTINUING MEDICAL EDUCATION (CME) RECORD

You are required to record a minimum of 100 hours every two-year cycle, at least 40 of which must be in Category I. Complete this CME Record form using the definitions provided on the reverse side of the form, keep a copy for your personal records and return the original with your 2006-2008 Physician Assistant Certification Renewal Application.

#### CATEGORY I

Program Title	Date	CME Hours	Sponsor	Location
PRINTATIONS   PX	JWE 9 2005	5	ACCHE	BURG
BIPOLAR DISORDER:	My 5 2005	3	AMA PRA	Proposita PH
RURAL HEALTH BYMDDSIUM	My 4 2005	4	1 cche	WHITSPIECD NH
UPDATE IN	My 2 2005	\$.5	Acche	DHMC Lebanon NH
JAAPA-BELF bssessement Quiz	My 4,2005		AAPA	SAAPA SOURVAL FMRCH 2005 UOLLY
TAAPA-SECT GUIZ	MY 4, 2005	l	AAPA	OCT ZOOY VOL 17

CATEGORY 11

**Program Title** Date CME Hours Sponsor Location DUERACTIUS BUIDDER TX STRATEGIES APRIL 15,2005 ALL PRA MONOGRAPH BREATHING EASIEL-APRIL 13, 2005 COPD MGT AMA PM MUNOGRAPH NEW YDNYNCES IN COPS MGT FLB 24, 2005 ALLA PRA MONOGRAPH BAC SUSTENICE 27.2 APRIL 1, 2005 AMA PRA CONCORD NH JAAPA -SECF JAMPA JOURNAL MARCH 29, 2005 SIND THEM 22322A APAA DEC. 2004 VOC.17 7132 - 294AT JAMPA JOURNAL FEB. 18, 2005 SING TURNSCESSEA AAPA SEPT. 2004 40617

19.5

(13,75)	
Total Category I Hours: 33.25 + Total Category II Hours: = Total Hours:	33.25

Your Signature:

189

Amy Borgman # 055 - 0030098



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

## 2006-2008 PHYSICIANS ASSISTANT CERTIFICATION RENEWAL APPLICATION CONTINUING MEDICAL EDUCATION (CME) RECORD

You are required to record a minimum of 100 hours every two-year cycle, at least 40 of which must be in Category I. Complete this CME Record form using the definitions provided on the reverse side of the form, keep a copy for your personal records and return the original with your 2006-2008 Physician Assistant Certification Renewal Application.

#### CATEGORY I

Program Title	Date	CME Hours	Sponsor	Location
LIPDATE IN REPRO-		į		
DUCTIVE HENETH	OCT. 22, 2004	ه	AMA PRA	BOSCAWEN NH
Ulter of tobacco TX	007.6 2004	1.5	Ama pra	MONOGRAPH
PRACIDISERVICE: CASE HX. PRUIEWS	JUNE 10 2004	6	AMA PRA	RINDOLPH, UT
RUBAL HEACTH SUMPOSIUM	May 5 2004	6	Ana PRA	BARUET UT
AL RESISTANT RESP. TRACT BACTERIA	April 27, 2004		AAPA	MONOGRAPH
PRAC IN-8 ERVICE		6		
	MARCH 26, 2004	/ 2 b . S	AMA PRA	CONCORD, NH

#### CATEGORY 1

Program Title	Date	CME Hours	Canaca	
r rogram ritte	Date	CIVIE HOURS	Sponsor	Location
EXTENDED CYCLE		_		
CONTRACEPTION	MARCH 18,2004		AMA PRA	MONOGRAPH
CURRENT STRATEGIES	•			
FOR HIP FX . PREUSINTION	MARCH 10, 2004	(	AAPA	TECECONFERENCE
HSU MGT: COMP.	,	_		
APPROACT TO TX.	MARCH 2004	1.5	AAPA	MONOGRAPH
FOCUS ON ONER -				
ACTIVE BLADDEL	Feb. 3 2004	1.5	AMA PRA	MONOGRAPH
PECUICHSVITH Y			<b>,</b> , , , , , , , , , , , , , , , , , ,	
the stadder	Feb. 16 2003	ĺ	AMA PRA	TELECONFSERICE
COCPOSCOPY IN-SUC				
	NOV. 21, 2003	2.2	AMA PRA	HANOUER NH

Total Category I H	ours: $\frac{\mathbb{R}^{3}}{\mathbb{R}^{3}}$	_ + Total Ca	tegory II Hours:	= Total Hours:	39
Your Signature:		25			
		)			

PAGES

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

## 2006-2008 PHYSICIANS ASSISTANT CERTIFICATION RENEWAL APPLICATION CONTINUING MEDICAL EDUCATION (CME) RECORD

You are required to record a minimum of 100 hours every two-year cycle, at least 40 of which must be in Category I. Complete this CME Record form using the definitions provided on the reverse side of the form, keep a copy for your personal records and return the original with your 2006-2008 Physician Assistant Certification Renewal Application.

#### CATEGORY I

Program Title	Date	CME Hours	Sponsor	Location
WOMEN'S HEACTH:		_		
FOCUS ON SEXUALITY	OCT. 17 2003	6	AM PRA	CONCORD NH
ADVANCE! IN	·			
CONTRICEPTION	OCT. 2003	2	AAPA	MONOGRAPH
NEW PARADIEM 3 FIR. ix. BACID-MINTUR disent		2	AAPA	MONOGRAPH
Met Jobstham Ringti	OCT. 2003	2	APA	Manograph
DEMENTIAS-MOT.	My 14, 2003	2	AMA ERA	MONOGRAPH

#### **CATEGORY II**

Program Title	Date	CME Hours	Sponsor	Location
PRECEPT APJUVA STUDENT 3.	JAN-APRIC 2004	20	PPNNE	BARREUT

Total Category I	Hours: +	Total Category II Hours:	🕒 = Total Hours: 🗟 🕌	r~3
Your Signature:	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		3 9	, 5 P5 <sup>2</sup>
			33.25	P31

Amy Borgman # 055-0030098

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

## PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomp	plete applications will be ret	urned. Attach additional sheets	as needed.
Name in full		CheruL	A.
	(Last)	(First)	(Middle)
Mailing Address			
183 Tall	oft KD	fice Name)	
williston.	VT. 05495	(E02)	
(City/State)	(Zip Code)	(Telephone 1	Number)
Vermont License #:	042-0007465		
Hospital(s) where yo	ou have privileges:	Hospital(s) Location	Specialty
Pletcher Al	ten Health Care	Burlington	oblogn
What arrangements l	nave you made for supervision	on when you are not available o	r out of town:
Concrage	by another f	hysician	
	CERTIFICATE OF SU	PERVISING PHYSICIAN	
the scope of practice, atta	(N), P.A. while under ached to this application, does not	31, I shall be legally responsible for a my supervision. I further certify that exceed the normal limits of my practic coordance with 26 VSA, Chapter 31,	the protocol outlining
I further certify that I have 12/15/0 (Date)	ve read the statutes and Board rules	s governing physician assistants.  Signature of Supervising Physician)	
	Co-signature of	V X W	
Note: A PA who prescrib	es controlled drugs must obtain ar	n ID number from DEA. PA's DEA	Vumber <u>MB07</u> 63234

Amy Borgman # 055-0030098

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

## SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	mplete applications	will be returned. A	attach additional shee	ts as needed.
Name in full	sm4h	SUZ	$\mathcal{T}$	C
	(Last)	(Firs	t)	(Middle)
Mailing Address	Plannod	Parentho	óg .	
183 Talo	oft RD.	(Office Nam	ie)	
Williston (City/State	J, TT C	(Street)	3(e08)	378-7232
(Chy/State	(	Zip Code)	(Telephone	e Number)
Vermont License	#: <u>042-00</u> 05	5990		
Hospital(s) where	you have privileges	: Hosp	oital(s) Location	Specialty
Fletcher	Allen Heat	th care	Birlington	ostaya
Hum Robbu	s assistants names at 190 - Barre, 195 - Hyde, F 1964-Willister		arrently supervise:  AMCHOLOS  AMCHOLOS  CHUNG  CHU	S-Burlington, VT Burl., VT Burl., VT.
CI	ERTIFICATE OF S	SECONDARY SU	PERVISING PHYS	ICIAN ,
consulted by the afore to this application, do	P.A. P.A. Psaid Physician Assistant	only when the primary  I further certify that it  I limits of my practice:	be legally responsible for supervising physician is the protocol outlining the and that in accordance with	unavailable and only when scope of practice attached
I further certify that I  12/18/0 (Date)	have read the statutes an	X DUSE	g physician assistants.  Multiple  dary Supervising Physicia	<u>1</u> an)
	/	•		



Amy Bogman # 055-0030098

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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

December 15, 2005

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

To Whom It May Concern:

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

• Amy Borgman

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

Sincerely,

Cheryl Gibson
Medical Director

in Borgman # 055-0030098

## Planned Parenthood

midlife health; well child care; general preventive health care.

Manage routine Noplant problems.

Manage routine DMPA problems.

Manage routine IUD problems.

Manage routine homonal contraceptive and HRT problems.

Order X-rays and sonograms for IUD localization.

Manage diaphragmand cervical cap problems.

Manage condom and spermicide problems.

B.

C.

D.

E.

F.

G.

2)

3)

1)

2)

1)

2) 1)

2)

3)

1)

2)

1)

-thood		Standing Orders for
Planned Parenthood	Nurse Practitioners, Certified Nurse Midu	vifes & Physician Assistants
of Northern New England		
The Family Planning Practitioner may:  A. Provide information and counseling of the provide information and the provide informat	on: family planning methods; sterilization; pregnancy; a	adoption; abortion; common lealth; infertility; maternity care;

Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.

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

gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care;

Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol.

Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol.

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

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

Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol.

G.	1)	Manage condom and spermicide problems.  Manage condom and spermicide problems.
	2)	Manage condom and spermicide problems.  BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervice seel and provide continuing evaluation and support of the natural methods of birth controls.
H.	Couns	sel and provide continuing of the second sec
	mucus	ate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and attempt to the patient of the patient
<b>j.</b>	Evalua	ate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory are patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory are patients and other medications in accordance with the PPNNE Medical tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical
<i>i</i> .	Other	tests as increased and state and federal laws.
	Fioto	col.  r, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.
J.	Order	r, administrational Protocol exindicated in the protocol
		nose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol nose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol Order serum HCG pregnancy test, titers and sonograms
K.		diagnosis as not the PPNNE MEUICAI Flotoon.
L.		
	Provi	ide services to patients in the maternity care, abortion, vasectionly, cer vical dysplacing, the interpretation of the services to patients in the maternity care, abortion, vasectionly, cer vical dysplacing, the interpretation of the services to patients in the maternity care, abortion, vasectionly, cer vical dysplacing, the services are services to patients in the maternity care, abortion, vasectionly, cer vical dysplacing, the services are services and materials are services as a service of the services are services and the services are services as a service of the se
M.	and i	ide services to patients in the matemity care, abortion, vasectomy, cervical dysplasta, throtalis, made and services to patients in the PPNNE Medical Protocol and Medical Protocol Supplements.  midlife programs as per the PPNNE Medical Protocol. Manage and follow-us reliable patients in accordance with the PPNNE Medical Protocol.
, i	Prov	ide routine gynecologic and general preventive health care as per the France with the PRNNE Medical Protocol.
N.	routi	ne and problem passens in occupant
Ο.	Perf	orm venipuncture; start and maintain I.V.'s.
	Orde	as and follow-up on outside laboratory tests and dispense treatment for conditions not speciment with the Medical Director's approval.
Ρ.	فسيفه	inal protocol ulusi me more a management and manage
_		to delegation from the Medical Director, to provide replications as indicated with or without parent;
Q.	PUIS	suant to delegation from the Medical Director, to provide reproductive health care to minors, including and suant to delegation from the Medical Director, to provide reproductive health care to minors, including and suant to delegation from the Medical Director, to provide and the suant to delegation from the Medical Director, to provide and the suant to delegation from the Medical Director, to provide and the suant to delegation from the Medical Director, to provide and the suant to delegation from the Medical Director, to provide reproductive health care to minors, including and suggestion from the Medical Director, to provide reproductive health care to minors, including and suggestion from the Medical Director, to provide reproductive health care to minors, including and the suggestion from the Medical Director, to provide reproductive health care to minors, including and the suggestion from the Medical Director, to provide reproductive health care to minors, including and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director, to provide and the suggestion from the Medical Director of the suggestion from the Medical Director of the suggestion from the Sugg
	con	ecially contraception and diagnosis and treatment of sexually transmitted infloating, 55 and treatment of sexually transmitted infloating, 55 are not provided.  Is sent if the minor may suffer probable health hazards if such services are not provided.
The	Family F	Planning Practitioner must:
	A.	Adhere to the PPNNE Medical Protocol.
	B.	
	C.	Follow-up and report all with processing and pro-
		ractice under the above standing orders
l ac	ree to p	nactice union.
	Ň	& Boxana PAC
	tom	
Pri	nt Name	
		William Shipping Cherd Ghan M.D. Medical Din
Çi	gnature	
Ψ.	gridita	
	. /	and provinces
PP	NNE For	m 10HR 9/21/04es
		E

Amy Borgman # 055-0030098

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

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

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

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

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

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

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

Amy Borgman # 055-0030098

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

#### Physician Oversight

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

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

#### Practice Protocols

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

#### Medical Management Team

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

#### Director of Clinical Quality Improvement

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

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

Medical Record and Patient Care Audits are conducted three times each year. The specific topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topics include: follow-up of abnormal pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

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

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

#### 2008 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

#### PARTI

Certificate #055-0030098	·	
1. Name: Amy S. Borgman PA-C		
2. Other Name(s), if any, under which	h you were certified or licensed in Vermon	t and elsewhere:
3. Work Address:		
PPNNE 183 Talcott Road WILLISTON VT 05495		
4. Home Address:		
City, State, Zip Code:		
Please check your preferred mailing a	address: □ Home Work s will be public and listed on the Board's w	ebsite)
5. Email Address		
6. Daytime Telephone Number: Area	Code:	
(802) 476-6696	grand vi	RECEIVED
7. Date of Birth:	SCAPLINA SCAN STATE OF STATE O	\$20 2 G 2007
8. Place of Birth:	TOTAL AND	Vermont Board of Medical Practice
9. Certification Examination raken (	enter date of examination)	
(10/15/07) NCCI	PA	
□ ( <u>/_/</u> ) State	Examination-Identify state:	All the second s
□ ( <u>/_/</u> ) Other	r Examination specify:	
10. Basis for Vermont Certification – (	Check box):	
Apprenticeship Trained     University Trained		

11. Do you have hospital privilege Hospital Name(s) and Location(s):	
12. In what year did you start work	ing as a physician assistant in Vermont? 1986
13. Did you practice in Vermont du	
14. Other states where you now he	old an active certification or license to practice:
15. States where you previously w	ere certified or licensed to practice:
16. Specialty: GYN	DEA Number: <u> </u>
17. Name and office address of cu	rrent EMPLOYER:
Name	Address
SUNDA	183 TALCOTT RD WILLISTON 05495
18. Please list (use additional shee as your PRIMARY and SECONDA Primary Supervising Physician(s):	et if necessary) name(s) and address(es) of physicians who currently serve RY SUPERVISING PHYSICIAN(S).
Name	Address 23 MANSFIECD AUE BURLINGTON UT OSYC
Secondary Supervising Physician(	5):
Name Susan Smith	Address 23 MANSFIELD AUE BURGHORD UT 0590
physician(s) review the most cu additions or deletions in duties	of Medical Practice requires that you and your primary supervising current scope of practice for your practice setting, paying attention to any and procedures. Please review, date and sign your scope of practice and ISING PHYSICIAN sign it as well. Attach a copy of your signed scope of
a. Has there been a change in □ Yes X No	your scope of practice which has not been reviewed by the Board?
20. Please provide a letter from you Physician Assistant within the μ	ur Supervising Physician attesting to the fact that you have practiced as a past twelve months.

21. Continuing Medical Education (CME) requirements:

- a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
- b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

#### **PART II**

"Yes" answers to Questions 23 - 46 require an explanation on Form A.

- 23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?

  □ yes 

  ino
- 24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
- 25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?
  - □ yes ⊿no
- 26. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
  - □ yes 🎢 no
- 27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
  - □ yes ⊅ao
- 28. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
  - □ yes Ano
- 29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
  - □ yes ⊿no
- 30. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
  - □ yes ⊅no
- 31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
  - □ yes 🖈no
- 32. Are you presently or have you ever been a defendant in a criminal proceeding?

## □ yes Ano

#### PART III

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

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

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



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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

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

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

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

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

#### **IMPORTANT**

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

#### Part IV - Statutory Profile Questions

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

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

		tion without them.		
38.	Criminal Convictions [See	26 VSA § 1368(a)(1)]	Check here if none	
	Please provide a descri or parking tickets) of wh copies of documentar	nich you have been conv	ies and misdemeanors; this icted within the past 10 year	includes DUI but not speedir rs Please provide comple
	(Conviction Date)	(Court)	(City/State)	(Crime)
39.	Nolo Contendere/Matters (	Continued [See 26 VSA	§ 1368(a)(2)]	chere if none
	or where sufficient facts	s of guilt were found and	hich you pleaded "nolo cont the matter was continued verte copies of documental	endere" ("I will not contest it without a finding by a court of tion for each matter.
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State) (City/State)	(Charge)
		,	· · · · · · · · · · · · · · · · · · ·	
0.	(Conviction Date)	(Court)	(City/State) (City/State)	(Charge)
· 40.	(Conviction Date)  (Conviction Date)  Vermont Board of Medical  Please provide a descr	(Court) (Court)  Practice Matters [See 26 iption of all formal charge	(City/State)  (City/State)  5 VSA § 1368(a)(3)]	(Charge) (Charge)  Z Check here if none

	(Date)	·	(Fi	inal Disposition	- Summa	<b>(y</b> )		
	(Date)	······································	(Fi	nal Disposition	- Summa	у)		
41.	Licensing or Certi		Matters in O	ther States [Se	e 26 VSA	§ 1368(a)(4)	]	
	states, the find	e a description of lings, conclusions ppealed, in those	s, and orders	of such authori	ties, and f	inal disposition	on of such mat	ters by
•	c/2							
(Da	ate of Final Disposit	ion) (Licensin	g or Certifica	ation Authority)	(Court)	(City/State)	(Nature of Ch	arge)
(Da	ite of Final Disposit	ion) (Licensin	g or Certifica	ation Authority)	(Court)	(City/State)	(Nature of Cha	arge)
42.	Restriction of Hos	pital Privileges [S	See 26 VSA	§ 1368(a)(5)]	Æ	Check here if	none	
	Revocation/Inv	voluntary Restrict	ions		,			
	were related to official of the h	e a description of competence or cospital after procedulete copies of d	character and dural due pro	d were issued b ocess (opportur	y the hosp hity for hea	oital's governi	ng body or any	v other
,	(Date)	(Hospital)	(State)	(Nature of Re	striction)	(Reason fo	or Restriction)	
	***************************************							
-	(Date)	(Hospital)	(State)	(Nature of Re	striction)	(Reason fo	r Restriction)	
	B. Other	Restrictions	Check he	ere if none				
	restriction of pr	a description of a ivileges at a hosp or character in the	ital taken in li	ieu of, or in settle	ement of,	a pending disc	ciplinary case r	elated
	\$				t-tatt			
	(Date)		(Ho	ospital)		(State)		
	(Nature of Acti	on)	C2 l. ti	(Action)				
	(Reason for Ac	ction)	☐ In lieu	□ In settle	ment			
12	Medical Malpractic	e Court ludamer	ts/Sattlamar	ofe [200.06.\/C	N & 4000/	~\/@^\]		
, J.	A. <u>Judgm</u>	C	k here if non		7 9 1300(	a)(OA)]		

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

		complaini	ng party if n	ot listed belo	w. Please	ite) in which a provide comp e, a copy of t	olete copie	s of docun	nentation,
		□ Judgm	ent □ Ar	bitration					
		(Date)	(Cou	rt) (St	ate) (Na	iture of Case)	(Amount	Assessed A	Against You
		□ Judgm	ent 🗆 Arl	oitration					
		(Date)	(Cou	rt) (St	ate) (Na	ture of Case)	(Amount	Assessed	Against You
	B.	<u>Settlemer</u>	nts Ch	eck here if n	one				
		within the complaini	past 10 yeang party if no	rs (10 years ot listed belo	from paym w. <b>Please</b>	s of medical ment date) in wiprovide compe, a copy of the	hich a payn olete copie	nent was aw <b>s of docu</b> m	varded to a nentation,
		(Date)	(Co	urt) (S	State)	(A	Amount of S	Settlement A	gainst You)
		(Date)	(Co	urt) (S	State)	. ( <i>P</i>	mount of S	Settlement A	gainst You)
44.		-	~	1368(a)(10)] rt practicing		cian Assistant′	?	1982	
45.	you are gr	anting perm	ission to hav	e this inform	ation poste	ote: Answering ed on the web ents, these qu	(This form	follows the	nswering, statutory
	Α.	<u>Appointme</u>	<u>ents</u>						
		Please pro faculties.	ovide inform	ation about y	our appoir	tments to med	dical school	or professi	onal school
		(School)	(City)	(State)	(Nature	of Appointmen	t) From	ı (year) To	(year)
		(School)	(City)	(State)	(Nature o	of Appointmen	t) From	ı (year) To	(year)
	B.	<u>Teaching</u>							
				ation regardi ast 10 years		sponsibility for	teaching gr	raduate med	dical
	(School	ol/Institution)	(Cit	y) (Sta	ate) (Na	ature of Teach	ing)	From (year)	To (year)

46.	Publications [See 26 VSA § 1368(a)(13)]
	Note: Answering #46 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)
47.	Activities [See 26 VSA § 1368(a)(14)]
	Note: Answering #47 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)
<b>4</b> Ω	Practice Setting (See 26.VSA \$ 4260/a)/45/1
<b>→</b> Q.	Practice Setting [See 26 VSA § 1368(a)(15)]
	What is the location of your primary practice setting?
٠	Town/City, State
49.	Translating Services [See 26 VSA § 1368(a)(16)]
	Please identify any translating services available at your primary practice location.  Are any translating services available at your primary practice location?  Yes □ No
	If yes, please describe the translating services available:
	In-house frame for locating translety services
50.	Medicaid/New Patients [See 26 VSA § 1368(a)(17)]
	A. Medicaid participation  Do you participate in the Medicaid program?  Do you participate in the Medicaid program?  ✓ Yes □ No
	B. New Medicaid Patients
	Are you currently accepting new Medicaid patients? Yes □ No

#### Part V

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

Date: 11.9.07

Applicant's Signature

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

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

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

You must answer questions 1, 2, and 3	You must	answer	questions	1.	2.	and	3.
---------------------------------------	----------	--------	-----------	----	----	-----	----

by such laws, and by the Office of Child Support.

Signature of Applicant

and all child support due under that order.

Please forward an "Application for Hardship".

#### Regarding Child Support

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

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

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 ueasonable hardship.

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he orshe is in good standing with the Department of Taxes. "Good standing" means that no taxes are dueand 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 Taxes, or

the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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

۸. برن	u must check one of the two statements below regarding taxes:
ĠV.	I hereby certify, under the pains and penalties operjury, that I am in good standing with respect to or in full compliance with a plan
CHARGE }	to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen
	years in prison, a \$10,000.00 fineor both).
	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 annueasonable hardship.  Please forward an "Application for Hardship".
	Regarding Unemployment Compensation Contributions
Title 21 § 137	'8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade onusiness
(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 a	ny employing unit unless such employing unit shall first sign a written declaration, wher the pains and penalties of perjury, that the
employing u	nit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of
contributions	s 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
alí contributi	ons 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	or any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a
payment plai	approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment contributions
or payments	in lieu of contributions due and payable would impose an unreasonable hardship.
, .,	and the second s
3. You	amust check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment
contributions	s:
	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a
<del></del>	payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or
	payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this
	application. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)
	application. (The maximum penalty for perjuly is 15 years in prison, a \$10,000.00 fine or both.)
	horsely contify that I amblot in good standing with respect to any purity of the
_	I hereby certify that I amNOT in good standing with respect to unemployment contributions or payments in lieu of unemployment
	contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that
	the licensing authority determine thatrequiring immediate payment of unemployment contributions or payments in lieu of
<b>\</b> .	unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
$\sim$	or
~4	I hereby certify that 21 V.S.A. § 1378 is not applicable tone because I am not now, nor have I ever been, an employer.
Social Securi	ty #* Date of Birth
The disclos	ure of your social security number is mandatory, it is solicited bine 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

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

Vermont Department of Health – Board of Medical Practice – 2008-2010 Physician Assistant Certification Renewal Page 19 of 19

information or omission of information is unlawful and may jeopardie-my license/certification/registration status.

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

## PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inc	complete applications	will be returned	<ol> <li>Attach additiona</li> </ol>	l sheets as needed.	
Name in full	Cibson (Last)	d	Denyl First)	(Middle)	
Mailing Address		Parently (Office)	Name)		
(City/Sta	COHT ROCK	(Street) CSY95 (Zip Code)	⊃ (Tele	88-8432 ephone Number)	
Vermont License	e#: <u>042-00</u> 0!	746S		,	
Hospital(s), wher	re you have privileges		Hospital(s) Location	n Specialty OBICY	
What arrangeme	nts have you made for	r supervision w	hen you are not ava	ilable or out of town	:
	CERTIFICAT	TE OF SUPER	RVISING PHYSIC	TAN	
the scope of practice	in accordance with 26 VS, P.A., attached to this application that a physician assistant	while under my so on, does not excee	upervision. I further ceed the normal limits of	ertify that the protocol ou my practice. I further ce	tlining
I further certify that  /2/17 (Date)	I have read the statutes an	<b>V</b> (	/ 1///	40	
Note: A PA who pre	C scribes controlled drugs m	co-signature of PA		's DEA Number M. B.	076323
			W		

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

#### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applic	cations will be returned. A	Attach additional she	eets as needed.
Name in full (Last)	h Sus	SGN st)	(Middle)
Mailing Address Pan	ned Parenth	$\infty d$	(imatic)
183 Talcott RD	Office Nan	ne)	·
Will Ston TT. (City/State)	(Zip Code)		8-8432 ne Number)
Vermont License #: 042-0	XXXX		,
Hospital(s) where you have privalent AHPO HO		pital(s) Location	Specialty OBIGIN
List all physician's assistants na Amy Borsman Ausus F Burns - Johanna Hauser		18t. Barre	Park VT.
CERTIFICAT	E OF SECONDARY SU	PERVISING PHY	SICIAN
I hereby certify that, in accordance with the application, does not exceed the Section 1741, the use of a physician a	, P.A. only when the primar Assistant. I further certify that e normal limits of my practice	y supervising physician the protocol outlining the	is unavailable and only when he scope of practice attached
I further certify that I have read the state of the state	V Su	ng physician assistants.  Sun Duck  Manual Physician assistants.  Supervising Physician Physician assistants.	ician)



SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE

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

December 14, 2007

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

Dear Ms. Hayes,

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

Amy Borgman

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

Sincerely,

Cheryl Gibson, M.D.



# National Commission on Certification of Physician Assistants

hereby affirms that

## Amy S. Borgman

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

Property Australia Continue

designation.

Certificate Number: 1011373

Dorothy D. Pearson, PAC, Chairman of the Board

Chart a Lithuan

Effective On: November 7, 2005

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

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

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

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

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

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

#### PLANNED PARENTHOOD Iorthern New England

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

#### The Family Planning Practitioner may:

- Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; midlife health; general preventive health care.
- Order and dispense hormonal contraceptives and HT/ET in accordance with the PPNNE Medical Protocol. 1) В.

Manage routine hormonal contraceptive and HT/ET problems. 2)

- Order special laboratory tests needed to prescribe hormonal contraceptives and HRT. 3)
- Insert and remove implant contraceptive systems in accordance with the PPNNE Medical Protocol. 1) C.
  - Manage routine implant system problems. 2)
- Inject Medroxyprogesterone acetate in accordance with PPNNE Medical Protocol. 1) D.
  - Manage routine DMPA problems. 2)
- insert and remove IUD's in accordance with the PPNNE Medical Protocol. 1) Ε.

Manage routine IUD problems. 2)

- Order X-rays and sonograms for IUD localization. 3)
- Fit and check diaphragms, cervical caps and other barrier devices in accordance with the PPNNE Medical Protocol. 1) F.
  - Manage diaphragm, cervical cap and other barrier device problems. 2)
- Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol. 1) G.
  - Manage condom and spermicide problems. 2)
- Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical Η. mucus and calendar.
- Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and ١. other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.
- Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws. J.
- Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
- Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, and sonograms.
- Provide services to patients in the abortion, cervical dysplasia, infertility, male services, and midlife programs as per the M. PPNNE Medical Protocol and Medical Protocol Supplements.
- Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up N. routine and problem patients in accordance with the PPNNE Medical Protocol.
- Perform venipuncture; start and maintain I.V.'s. O.
- Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.
- Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and Q. especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

#### The Family Planning Practitioner must:

Adhere to the PPNNE Medical Protocol. Α.

Obtain physician consultation in all non-routine clinical matters.

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

I agree to practice under the above standing orders

Print Name

Signature

Date

Collaborating Physician: Cheryl Gibson, MD, Medical Director

19

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

#### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Name in full Boyman Kum (Middle)	
(Last) (Middle)	
	-
Mailing Address Planned Parenthood	
(Office Name) 183 Tal Cott Road	
Williston, VT. 05495 388-8432	
(City/State) (Zip Code) (Telephone Number)	
Vermont License #: <u>0420010</u>	
Hospital(s) where you have privileges: Hetcher Allen Heatthcare Burlington, VT. OBIOUN	
List all physician's assistants names and addresses you currently supervise:  Amy Borgman, August Burns, Johanna Hauser, Katra King  Catherine Nicholas, Janet Young.	
CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN	
I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activition of Anna Consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.	
I further certify that I have read the statutes and Board rules governing physician assistants.	



#### STATE OF VERMONT BOARD OF MEDICAL PRACTICE

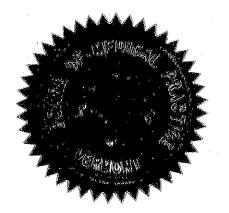
#### PROFESSIONAL CERTIFICATE

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

Amy Borgman, PA

P.A. Certification Number: 055-0030098

Valid only while working under the supervision of Cheryl Gibson MD, Susan Smith MD, and Kym Boyman MD, at Planned Parenthood of Northern New England, 183 Talcott Road, Williston, VT.



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

## VERMONT BOARD OF MEDICAL PRACTICE

at Burlington, in the county of Chittenden, State of Vermont, this 21<sup>st</sup> day of February, A.D. 2007

Administrative Assistant



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

#### 2010 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

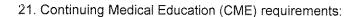
Certificate #055-0030098	PART I	
1. Name: Amy S. Borgman PA-	-C	
· · · · · ·	er which you were certified or licensed in Vermo	ont and elsewhere:
3. Work Address:  PPNNE  183 Talcott Road  WILLISTON VT 05495	but your resident to the second secon	JAN - 8 2010
4. Home Address:  City, State, Zip Code:		
Please check your preferred m (This a  5. Email Address:  6. Daytime Telephone Number:	address will be public and listed on the Board's	website)
(802) 476-6696  7. Date of Birth:		
Place of Birth:      Certification Examination Take	ken – (Check box and enter date of examination	on):
(10/15/07) (10/15/07)	NCCPA State Examination-Identify state:  Other Examination specify:	
10. Basis for Vermont Certificat	tion – (Check box):	

Apprenticeship Trained

University Trained

†1. Do you have hospital privileges in Vermont? ☐ Yes ☑ No Hospital Name(s) and Location(s):				
12. In what year did you start working as a physician assistant in Vermont? \( \lambda \ 8 \lambda \)				
13. Were you in active clinical practice in Vermont during the past 12 months? ☐ Ves ☐ No				
14. Other states where you now hold an active certification or license to practice:				
15. States where you previously were certified or licensed to practice:				
16. Specialty: <u>Gソル</u> DEA Number: <u>れるつもろよるリ</u>				
17. Name and office address of current EMPLOYER:				
Name Address 183 TALCOTT R.Q.				
Planned Parenthood of Northern New England WILLISTON UT 05495				
18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).				
Primary Supervising Physician(s):				
Name De Cheng Gilson 23 MANSFIELD AUE BLOCK UT 05401				
Secondary Supervising Physician(s):				
Name Susan Smith 33 marshed Ave Burly 1.05401				
19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application. a. Has there been a change in your scope of practice which has not been reviewed by the Board?				
□ Yes ☑ No				
20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a				

Physician Assistant within the past twelve months.



- (a) NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
- b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

#### PART II

"Yes" answers to Questions 23 - 47 require an explanation on Form A.

- 23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
- 24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

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

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

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

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

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

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

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

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

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

#### PART III

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

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

- 34. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?
- 35. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

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

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive Vermont Department of Health – Board of Medical Practice – 2010-2012 Physician Assistant Certification Renewal

ongoing treatment (with or without medication) or have participated or do participate in a monitoring program. 38. Are grantly engaged in the illegal use of controlled substances? In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine. **IMPORTANT** Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line). Part IV - Statutory Profile Questions The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your practitioner profile is located at the following website http://healthvermont.gov/hc/med\_board/profile\_search.aspx. Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them. 39. Criminal Convictions [See 26 VSA § 1368(a)(1)] Check here if none Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years Please provide complete copies of documentation for each matter. (Conviction Date) (Court) (City/State) (Crime) 40. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)] Check here if none Please provide a description of all charges to which you pleaded "noto contendere" ("I will not contest it")

(Court)

(Conviction Date)

or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. Please provide complete copies of documentation for each matter.

(City/State)

(Charge)

Ţ.,	Vermont Board of Medical P		20 (0)(3)	
	Please provide a descrip Board of Medical Practic appealed.	tion of all formal cha e (including stipulati	arges served, findings, coons), and final dispositio	onclusions, and orders of the n of such matters by the courts, i
	(Date)	(Fir	nal Disposition - Summar	y)
42.	Licensing or Certification Aut	thority Matters in Otl	ner States [See 26 VSA	§ 1368(a)(4)]
	states, the findings, conc	lusions, and orders	of such authorities, and f	or certification authorities of othe inal disposition of such matters by pies of documentation for each
(Da	ate of Final Disposition) (Li	censing or Certificat	ion Authority) (Court)	(City/State) (Nature of Charge)
43.	Restriction of Hospital Privile	ges [See 26 VSA §	1368(a)(5)]	/ Check here if none
	Revocation/Involuntary R	estrictions		
		tion of any royacatic		
	were related to competen	ice or character and r procedural due pro	were issued by the hosp cess (opportunity for hea	oital's governing body or any other
	were related to competen official of the hospital afte	ice or character and r procedural due pro s of documentatio	were issued by the hosp cess (opportunity for hea	oital's governing body or any other
	were related to competen official of the hospital afte provide complete copie	rce or character and r procedural due pro s of documentatio	were issued by the hosp cess (opportunity for hea n for each matter.  (Nature of Restriction)	oital's governing body or any othe aring) was afforded to you. <b>Please</b>
	were related to competen official of the hospital afte provide complete copie  (Date) (Hospital afte provide Complete Copie (Date) (Hospital afte provide a descript restriction of privileges at	r procedural due pro s of documentatio  tal) (State)  s Check he ion of all resignation a hospital taken in lie	were issued by the hospicess (opportunity for hearn for each matter.  (Nature of Restriction)  re if none s from, or non-renewal of the property of the control of the cont	on of your hospital privileges that pital's governing body or any other aring) was afforded to you. Please (Reason for Restriction)  f, medical staff membership or the a pending disciplinary case related te copies of documentation for
	were related to competen official of the hospital afte provide complete copie  (Date) (Hospital afte provide complete copie)  B. Other Restriction Please provide a descript restriction of privileges at to competence or characteristics.	tce or character and r procedural due pro s of documentation tal) (State)  S Check he ion of all resignation a hospital taken in lieter in that hospital.	were issued by the hospicess (opportunity for hearn for each matter.  (Nature of Restriction)  re if none s from, or non-renewal of the property of the control of the cont	oital's governing body or any other aring) was afforded to you. Please (Reason for Restriction)  f, medical staff membership or the a pending disciplinary case related
	were related to competen official of the hospital afte provide complete copie  (Date) (Hospital afte provide complete copie)  B. Other Restriction Please provide a descript restriction of privileges at to competence or characteach matter.	tce or character and r procedural due pro s of documentation tal) (State)  S Check he ion of all resignation a hospital taken in lieter in that hospital.	were issued by the hosp cess (opportunity for hea n for each matter.  (Nature of Restriction)  re if none s from, or non-renewal of eu of, or in settlement of, Please provide comple	oital's governing body or any other aring) was afforded to you. Please (Reason for Restriction)  f, medical staff membership or the a pending disciplinary case related te copies of documentation for

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

		None reporte	d				
		□ Judgment	☐ Arbitration				
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against Yo	u)
		□ Judgment	☐ Arbitration				
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against Yo	u)
	В.	<u>Settlements</u>	Check here	e if none			
		within the past complaining pa	10 years (10 yearty if not listed al disposition	ears from p below. <b>Ple</b>	payment date) in wh ase provide comp	alpractice claims against you lich a payment was awarded to a lete copies of documentation, le complaint for each matter.	
		(Date)	(Court)	(State)	(A	mount of Settlement Against You	1)
		(Date)	(Court)	(State)	(A	mount of Settlement Against You	<u>1</u> )
45.		Practice [See 26 inth and year did			<b>32</b> - hysician Assistant?	August 1983	_
46.	you re gra	nting permission	to have this inf	ormation p	osted on the web. (*	#46 is optional. By answering, This form follows the statutory estions may overlap.)	
	Α.	Appointments					
		Please provide faculties.	information ab	out your ap	pointments to med	ical school or professional schoo	4
		or pursu	> C-	TAN VT	INTUNET E	Acusty along the	
		(School) (Cit	y) (Sta	ate) (Nat	ure of Appointment	Acuct 1 09 -> 5 100 ) From (year) To (year)	_
		(School) (Cit	y) (Sta	ate) (Nat	ure of Appointment	) From (year) To (year)	_

	B. <u>leacning</u>	
	Please provide information regarding your responsibility for teaching graded education within the past 10 years.	duate medical
	(School/Institution) (City) (State) (Nature of Teaching) Fr	<u> 入の6 → p μe</u> om (year) To (year)
47.	Publications [See 26 VSA § 1368(a)(13)]	
	Note: Answering #47 is optional. By answering, you are granting permission to hat posted on the web. Please provide information regarding your publications in perliterature within the past 10 years.	eve this information er-reviewed medical
	None reported	
	(Title) (Publication)	(Year)
48.	(Title) (Publication)  Activities [See 26 VSA § 1368(a)(14)]	(Year)
	Note: Answering #48 is optional. By answering, you are granting permission to ha posted on the web. Please provide information regarding your professional or collactivities and awards.  None reported	ve this information mmunity service
	(Activities or Awards)	
49.	Practice Setting [See 26 VSA § 1368(a)(15)]	
	What is the location of your primary practice setting?  Barre, VT  Gowashington St. OSott  Town/City, State	
50.	Translating Services [See 26 VSA § 1368(a)(16)]	
	Please identify any translating services available at your primary practice location. Are any translating services available at your primary practice location?	
F.4	If yes, please describe the translating services available: None  Availability of Professional translating source	)
51.	Medicaid/New Patients [See 26 VSA § 1368(a)(17)]  A. Medicaid participation	
	Do you participate in the Medicaid program? ✓ Yes ☐ No	

Ģ∕Yes	No

#### Part V

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

Applicant's Signature

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

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.
Name in full CibSon Chery (Middle)
Mailing Address Planned Parent hood (Middle)
- 33 Mansfield Ave.
(City/State) (Street) (Street) (Street) (Street) (Street) (Telephone Number)
Vermont License #: <u>042-00</u> 07465
Hospital(s) where you have privileges: Hospital(s) Location Specialty
Fletcher Allen Hearth CARE Burlington oblown
What arrangements have you made for supervision when you are not available or out of town:
24/1 on CAILSEVICE/BACKER UP by two mots.
CERTIFICATE OF SUPERVISING PHYSICIAN
I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of the scope of practice attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.
I further certify that I have read the statutes and Board rules governing physician assistants.    12/22/09
Co-signature of PA:
Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number 178076323

### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete applications wi	ll be returned. Attach	additional sheets as r	ieeded.
Name in full	Smith	<u>Susc</u>		***
	(Last)	(First)	1)	Middle)
Mailing Address	Planned P	Parenthood	/	
<u>33. U</u>	)ansfreid x	(Office Name)	- Annie A	
Burli	noton VI	(Street)	863-900	
(City/State)	(Ži <sub>I</sub>	Code)	(Telephone Num	ber)
Vermont License #:	042-000	5990	<b>a</b> 9	
Hospital(s) where yo	u have privileges:	Hospital(s	Location S <sub>1</sub>	oecialty N
List all physician's a	ian 90 Wa	addresses you currently the state of the sta	· Barro JT.	
±	iguser as n	Jansfield Av	e. PUNL VI-	
HOUS HIGH	th 6 Rober	15 NO. Ruth	rnd, VT.	MEK)
CER	TIFICATE OF SEC	CONDARY SUPERV	ISING PHYSICIAN	1
AMU GOTAT consulted of the aforestic	P.A. only P.A. only Physician Assistant. 1 f ot exceed the normal lim	Chapter 31, I shall be lega y when the primary superv urther certify that the protits of my practice and that been posted.	rising physician is unavaila ocol outlining the scope of	able and only when f practice, attached
I further certify that I have	e read the statutes and Bo	pard rules governing physi	cian assistants	
(2/29/09 (Date)		X OUSE	n Mul	**.
(Date)	()	Signature of Secondary Su	pervising Physician)	

#### SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomp	plete applications will be re	eturned. Attach addition	onal sheets as needed.
Name in full	Boyman (Last)	Kym (Rirst)	(Middle)
Mailing Address	Planned Pay	Egyptogg	(Widdle)
	23 Manstr	Office Name)	
	DUNINGTON.	treet) VT: 05401	863-900/
(City/State)	(Zip Code	e) (T	'elephone Number)
Vermont License #:	0420010597		
Hospital(s) where yo	ou have privileges:	Hospital(s) Locat	ion Specialty
FAHC	Buding	ston, T.	OBIGUN
Amy Boren Solvanna H Anne Hildre	ssistants names and addres an 90 Washing auser 23 mo	stoin st. Ban costed Aye. S NO. Rut	BUYL, VTI
CERT	IFICATE OF SECONDA	RY SUPERVISING	PHYSICIAN
of HIM BOYGO only when consulted by t practice, attached to this	ccordance with 26 VSA, Chapter , P.A. only when the aforesaid Physician Assistant application, does not exceed the n 1741, the use of a physician as	nen the primary supervising I further certify that the p normal limits of my praction	physician is unavailable and
I further certify that I have	re read the statutes and Board ru	les governing physician ass	istants.
1.5.10		ICA	
(Date)	(Signati	are of Secondary Supervision	ng Physician)

#### **Certification Status Report**

NCCPA nccpa@nccpa.net • (678) 417-8100 • 12000 Findley Road Suite 200 • Duluth, GA 30097

Advancing Certified PAs Promoting Excellence Making a Difference

Amy Borgman is currently certified by NCCPA and holds identification no.1011373.

Identification no. 1011373 will remain valid until 12/31/2011. This PA was initially certified on 1/15/1983. However, this PA may or may not have been continuously certified during this timeframe.

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Code of Conduct for Certified and Certifying PAs CENTRAL OFFICE

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

December 21, 2009

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

Dear Ms. Hayes,

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

Amy Borgman

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

Sincerely,

Cheryl Gibson, M.D.

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

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

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

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

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

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

Physician Assistant

Physician Assistant

Date

12/22/09

Supervising Physician

Date

# PLANNED PARENTHOOD of Northern New England

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

#### The Family Planning Practitioner may:

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

#### The Family Planning Practitioner must:

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

I agree to practice under the above standing orders

Print Name

Signature

2 · 24.00

Collaborating Physician: Cheryl Gibson, MD, Medical Director

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

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

You	must	answer	questions	1,	2,	and	3.
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#### 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)

impose an unrea	sonable hardship. (15 V.S.A. § 795)
□ I h an	<u>ust</u> check one of the two statements below regarding child support regardless whether or not you have children: ereby 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 d 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 d all child support due under that order.
	or
rec	ereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby quest that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. ease forward an "Application for Hardship".
Title 32 & 2442 re	Regarding Taxes quires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the
person certifies t returns have bee	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 n filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or hority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2. You mu	ast check one of the two statements below regarding taxes:
XQ In	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 ars in prison, a \$10,000.00 fine or both).
l h	ereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and ereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. ease forward an "Application for Hardship".
	Regarding Unemployment Compensation Contributions
(including a licen space with any eremploying unit is contributions due all contributions the liability for an payment plan app	quires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business is to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate imploying unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of eas of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) by contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a proved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions are of contributions due and payable would impose an unreasonable hardship.
3. You mu	st check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment
pay pay	ereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a yment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or yments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this plication. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)
cor the	ereby certify that I am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment intributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that illicensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of employment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
□ lhe	ereby certify that 21 V.S.A. § 1378 is not appl <u>icable to me because I</u> am not now, nor have I ever been, an employer.
Social Security #	Date of Birth
the Department of	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 f Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected 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

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

Page 23 of 23

#### 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:		18		Manuel
				Ç
Date:	(	1.16.	) <sup>9</sup> ,	_

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

108 Cherry Street, P.O. Box 70
Burlington, VT 05402-0070
http://healthvermont.gov/hc/med\_board/bmp.aspx
802-657-4220

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

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

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

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

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

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

-	Signature		Date
	Print Name	Vermont License or	Certification Number
Print M	ailing Address _		
Telepho	one		

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

### 2012 PHYSICIAN ASSISTANT LICENSURE RENEWAL APPLICATION



#### **PARTI**

License # 055-0030098
1. Name: Amy S. Borgman PA-C
2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:
3. Mailing Address(es):
PPNNE 90 Washington Street BARRE VI. 05641
4. Home Address:
City, State, Zip Code:
5. Email Address:
6. Daytime Telephone Number: Area Code:
(802) 476-6696
7. Date of Birth:  JAN - 9 2012
8. Place of Birth:
9. Certification Examination Taken – (Check box and enter date of examination):
(10/15/67) NCCPA
(//) State Examination-Identify state:
(//) Other Examination specify:
10. Basis for Vermont Certification – (Check box):
□ Apprenticeship Trained  ☐ University Trained
11. Do you have hospital privileges in Vermont? ☐ Yes ☑ No Hospital Name(s) and Location(s):
40 L L ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )
12. In what year did you start working as a physician assistant in Vermont?
13. Were you in active clinical practice in Vermont during the past 12 months? ☐ Yes ☐ No

14. Other states where you now hold an active certification or license to practice:
15. States where you previously were certified or licensed to practice:
16. Specialty: FAMILY FLANDING DEA Number: MB0763234
17. Name and office address of current EMPLOYER(S):
PPNNE, <del>23 Mansfield Avenue</del> , Burlington, VT 05401
Name Sura 301 Address
18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S). Attach signed sheets for each practice location.
Primary Supervising Physician(s):
Name Regan Theiler PPNNE 183 St Paul St Buzz UT 05401
Secondary Supervising Physician(s):  Name Reme Novello PFNNE GROET North Futbank VT 0870
<ul> <li>19. Delegation Agreement: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current delegation agreement for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your delegation agreement and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed delegation agreement to this application. This should be done for each practice location and included with this renewal.</li> <li>a. Has there been a change in your delegation agreement which has not been reviewed by the Board? ☐ Yes ☐ No</li> <li>20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.</li> </ul>
21. Continuing Medical Education (CME) requirements:
<ul> <li>a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof c CME completion.</li> </ul>
b. For all others, an explanation of requirements and a CME Record form must be completed.
<ol> <li>Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.</li> </ol>
PART II

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

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

"Yes" answers to Questions 23 - 47 require an explanation on Form A.

o yes oxno
24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes 文no
25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art lieu of disciplinary action or any other reason?
□ yes À no
26. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
□ yes ≱no
27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes ≱no
28. Have you ever discontinued your education, training, or practice for a period of more than three months?
xyes ano
29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes ※no
30. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated agains you?
□ yes 🔀 no
31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
□ yes ★no 32. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.
□ yes 🛒no
33. Are you presently or have you ever been a defendant in a criminal proceeding?
□ yes 🔭 no
PART III
(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)
Any "yes" response to the questions below must be fully explained on the enclosed Form A.
34. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?
35. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

in

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

"Ability to practice medicine" - This term includes:

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

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

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

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited Vermont Department of Health – Board of Medical Practice – 2012-2014 Physician Assistant Licensure Renewal Page 3 of 19

to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

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

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

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

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

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

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

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

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

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

#### **IMPORTANT**

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

#### Part IV - Statutory Profile Questions

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your practitioner profile is located at the following website <a href="http://healthvermont.gov/hc/med\_board/profile\_search.aspx">http://healthvermont.gov/hc/med\_board/profile\_search.aspx</a>.

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

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

Check here if none

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	tr ·			
(Conviction Date)	(Court)	(City/State)	(Crime)	•
olo Contendere/Matters C	Continued [See 26 VSA	\ § 1368(a)(2)] Chec	ck here if none	in the same
Please provide a desci sufficient facts of guilt v	ription of all charges to vere found and the mat	which you pleaded "nolo ter was continued without ntation for each matter.	contendere" ("I will not	contest it") o
(Conviction Date)	(Court)	(City/State)	(Charge)	**************************************
ermont Board of Medical I	Practice Matters [See 2	6 VSA § 1368(a)(3)]	Check here if none	380 1/12/
Please provide a descri Practice (including stipu	ption of all formal charg lations), and final dispo	ges served, findings, concl osition of such matters by t	usions, and orders of the	
(Date)	(Final	Disposition - Summary)		<del></del>
censing or Certification A		r States [See 26 VSA § 1	368(a)(4)]	
findings, conclusions, a	nd orders of such autho	rges served by licensing or prities, and final disposition es of documentation for o	of such matters by the c	of other stat ourts, if appe
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Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation** 

	□ In	re of Action) settlement			(Action)				□ In lieu
	(Rea	son for Action)							
44.	Medical N	Malpractice Cour	t <sub>v</sub> Judgments/S	ettlements	[See 26 VSA §	1368(	a)(6A)]		
	Α.	Judgments	Check he	re if none	Olk ilis	1,2	,		
		against you ai payment date complete co	nd all medical : ) in which a pa	malpractice yment was <mark>ientation,</mark> i	arbitration awar awarded to a co	ds ag mplai	ion of all medical malpradiainst you within the past ning party if not listed belosition and, if possible,	10 years (1 ow. <b>Please</b>	0 years from
		None reporte	ed						
		☐ Judgment	☐ Arbitratio	n					
		(Date)	(Court)	(State)	(Nature of Cas	se)	(Amount Assessed Again	nst You)	
		□ Judgment	□ Arbitratio	n					
		(Date)	(Court)	(State)	(Nature of Cas	e)	(Amount Assessed Agair	nst You)	
	В.	<u>Settlements</u>	Check he	re if none					
		a copy of the	complaint for	r each mat	es or document ter.	ation,	, to include final dispos	ition and,	if possible,
		(Date)	(Court)	(State)		(Am	ount of Settlement Again	st You)	
		(Date)	(Court)	(State)		/ A no	out of Cottlement Assis		
		(Date)	(Court)	(State)		(Am	ount of Settlement Again	st You)	
45.		Practice [See 26			082		,		
	What mo	nth and year did	you start pract	ticing as a l	<sup>P</sup> hysician Assista	int? _	Sept. 1784		
i	permission	nents/Teaching n to have this info ng appointments	ormation poste	d on the we	eb. (This form fol	ring # lows 1	46 is optional. By answer the statutory wording. Sin	ing, you re ce most ap	granting pointments
	Α.	Appointments							
		Please provide	information a	bout your a	ppointments to r	nedica	al school or professional	school facu	ilties.
		UVM PS (School) (Ci	ty) (Si	て へる tate) (Na	Quest Prost	ent)	しいーションしい From (year) To (year	Šalie.	

(Action)

(Nature of Action)

From (year) To (year)

		(School)	(City)	(State) (Na	ature of Appointment)	From (year	To (year)	<del></del>
	В.	Teaching		ख				
	<del>-</del> -		ovide informatio ars.	n regarding yo	our responsibility for te	eaching graduat	e medical edu	cation within the
	u	VM	BURL	, IV	preceptor	-	1047ts	. A
		ol/Institution)	(City)	(State)	(Nature of Teachin	g) From	(year) To (yea	ar)
47.	Public	cations [See	26 VSA § 1368	(a)(13)]				
	Note: web. years.	Please provi	47 is optional. E de information i	By answering, regarding your	you are granting pern publications in peer-l	nission to have reviewed medic	this informatior al literature wit	n posted on the hin the past 10
	None	reported		<u> </u>				
			(1	Publication)		(Ye	ear)	(Title
			(			(1)	Jul )	/T(4)
	••••		(1	Publication)		(Ye	ear)	(Title
48.	<u>Activit</u>	ies [See 26	VSA § 1368(a)(	[14)]				
		reported		Activities or Av	professional or comn	numity service a	ctivities and av	varus.
	***************************************			Activities of Av	valus)			
49.	Practice S	Setting [See	26 VSA § 1368	(a)(15)]				
	What	is the locatio	n of your prima	ry practice set	ting? Barre, VT			
	Town/	City, State						
50.	Translatin	g Services [	See 26 VSA § 1	[368(a)(16)]				
					e at your primary pract mary practice location		No	
	If yes,	please desc	ribe the translat	-	vailable: Non			
51.	Medicaid/I	New Patients	[See 26 VSA				**************************************	
	A.		<u>articipation</u> ticipate in the N	Medicaid progr	am? ÀYes □	No		·
	B.		aid Patients		, and the second			•
		Are you cu	rrently acceptin	g new Medica	id patients? 🗡 Yes	s □ No		

Part V

Date:	11.20.11			Commence and the commence of t
		Applicant's Signature		,
		Commence of the Commence of th	a market and a mar	

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

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

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

### PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Questions 23 and 24) withdrawai or denial of License	
State	Year An II
terminated	
A/A	<i>p</i> .
3	
(Question 25) Voluntarily surrendered or resigned a lic documents	cense to practice medicine or any healing art -
State	Year
Circumstances	
(Question 26) Disciplinary charges or action - Attach d	
Name of organization involved	Date
Duration	
Action taken (circle all that apply)	
01 Revocation of right or privilege 02 Suspension of right or privilege 03 Censure 04 Written reprimand or admonition 05 Restriction of right or privilege 06 Non-renewal of right or privilege 07 Fine 08 Required performance of public service 09 Education/Training/Counseling/Monitoring 10 Denial of rights or privilege	12 Leave of absence 13 Withdrawal of an application 14 Termination or non-renewal of contract 15 Medical Records Suspension 16 Probation 17 Assurance of Discontinuance 18 Consent Agreement 19 Letter of Agreement 20 Expulsion from Membership 21 Reprimand 22 Other (specify)
Circumstances	
•	
(Question 27) Denial of examination privileges - Attach	documents
State	Year
Circumstances under which examination privileges denied	
The state of the s	

(Questions 28 and 29) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training	g Program(s) <u> </u>	K @ Bane	3 WM99		
Location of Progra	ıms		Ye	ar	
Circumstances	Maternity 1	eave of 41		90-3/92	
		<u> </u>		92 -> 10/9:	
(Question 30) Aff	ecting Health Care Insti	itution Staff Privilege	es, Employment or A	Appointment - Attac	h documents
Institution involved				· ·	1
Location	·	y i	Yea	ar	
Circumstances		,			
(Question 31) Priv	vilege to prescribe cont	trolled substances -	Attach documents		
Name of organizat	ion involved				
Type of restriction			Date		
Circumstances of r					
				·	
(Question 32) Inte	rnet prescribing				
Please provide a g	general description of y	our practice of inter	net prescribing		
(Questions 33 and	d 35) Criminal Investiga	tion - Proceeding - A	Attach documents		
,		_			
				** ***********************************	
	·				
				······	
•					
Conviction?					
Plea? Yes _	No				

(Question 34) Investigation by any other	
Name of Licensing Board	Date
Circumstances	
	atment, use of chemical or illegal substances
Treating organization	
Address	Telephone
Type of diagnosis, condition or treatment - f	field of practice - use of chemical substances
	to
Dates of treatment	to
Name of Rehabilitation/Professional Assista	ance or Monitoring Program
Address	Telephone
Contact person at Program	

#### (Question 44) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary. Insurer\_\_\_ Claimant name \_\_\_\_\_ Description of alleged claim (allegations only): This does not constitute an admission of fault or liability. Please indicate: 1. Patient's condition at point of your involvement: 2. Patient's condition at end of treatment; 3. The nature and extent of your involvement with the patient: 4. Your degree of responsibility for the course of treatment in leading to the claim; and 5. Narrative of event. If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart: Your role (circle one): 01 Anesthesiologist 11 PGY 4 02 Primary Care Physician 12 PGY 5 03 Referring Physician 13 PGY 6 04 Attending Physician 14 PGY 7 05 Consultant Specialist 15 Workmen's Compensation Evaluator 06 Surgeon 16 Court Psychiatrist 07 Fellow 17 On-Call Physician 08 PGY 1 18 Group Practitioner/Partner 09 PGY 2 19 Other: Specify 10 PGY 3 20 Unknown Your Legal Representative in this matter (include name, address and telephone number) Address \_\_\_\_\_ City, State, Zip 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):	JudgeJı	ury	_Arbitration Panel	
Decision:	Award:			·
If your case was appealed, indicate the folk Date appeal decided: (month, day, year) _	owing: Date appeal	filed (month	, day, year)/_	<u>/</u>
If your case was settled, indicate the followi	ing:			
Settlement amount paid on your behalf:				
Total settlement amount:				
Date of settlement: (month, day, year)				
Case dismissed against you	Against all defenda	nts		
Important: In addition to the above infor and release, or other final disposition of	mation, please atta the claim. This in	ach a copy of formation c	of the complaint and an be obtained from	l final judgment, settlement ı your legal representative.
Additional information, if any:				
				·

#### PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. In	ncomplete applica	tions will be returned. Attac	ch additional sheets	as needed.
Name in full _	Theiler	Regan (First)		Nell (Middle)
	(Last)	(Pirst)		(Middle) .
	ss <u>Planned</u> Paul Str	Parenthood of No. (Office Name)	rthern New E	ingland
		/C1		
Burling	ton VT		802-863	-6326
(City <b>%</b> t	tate)	(Zip Code)	(Telephone N	Jumber)
Vermont Licen	se #: <u>042-0012</u>	2264		
	ere you have privi r Allen He	alth Care III (	(s) Location of the ster Ave.  Ington, VT	Specialty OB GYN
		0540		
What arrangem	ents have you ma h call Ser	de for supervision when you vice	are not available or	out of town:
	CERTIFIC	CATE OF SUPERVISING	PHYSICIAN	
outlining the scope	orgman of practice, attached	26 VSA, Chapter 31, I shall be long.  P.A. while under my superviol to this application, does not except that a physician assistant is used,	sion. I further certify the	nat the protocol  my practice. I
further certify tha	at I have read the state	ites and Board fules governing ph	ıvsician assistants.	
12/2/11 (Date)			pervising Physician)	
<u> </u>		Co-signature of PA:	pervising i hysician)	
lote: A PA who pr	escribes controlled d	rugs must obtain an ID number fi	OM DEA PA'ADEA'	Jumbar MRA-1/222

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applica	ations will be returned. Attach additi-	onal sheets as needed.
Name in full Novello	Renee	
(Last)	(First)	(Middle)
Mailing Address Plannes	Parenthood of Nort	hern New England
la Robe	rts North	and the second s
Rutland, VT	(Street) 05 701 - 3120 802	2-775-2333
(City/State)	(Zip Code)	relephone Number)
Vermont License #: <u>042-001</u>	<u>/1</u> 95	
Hospital(s) where you have privi Mt. Ascutney Hospital Health Center	and 289 County R Windsor, VT	
	05089	
List all physician's assistants nar	mes and addresses you currently supe	ervise;
AUBUST BURGE 213 F	Shington St. Barre, VT 0564 Main St. Hyde Park, VT o	A second
Johanna Hower, 183	St. Paul St., Burlington,	VT 05401
	OF SECONDARY SUPERVISING	
only when consulted by the aforesaid Ploractice, attached to this application, do	126 VSA, Chapter 31, I shall be legally resp., P.A. only when the primary supervising the primary supervision assistant has been posted.	g physician is unavailable and
further certify that I have read the state  12/16/( (Date)	utes and Board rules governing physician as: (Signature of Secondary Supervisi	

#### 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:		39	f
	The state of the s		*
Date:	•	(1.18.11	

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

#### APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer questions 1 and 2

Regarding Child Support Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795) You <u>must</u> check one of the two statements below regarding child support regardless whether or not you have children: I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order. I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship". **Regarding Taxes** Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113) 2. You must check one of the two statements below regarding taxes: 🛕 I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both). I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".  $\Box$ Social Security # Date of Birth \* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes 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

> Anny BORGMAN 085-0030098



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

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

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

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

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

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

Amy Borgman

Regan Theiler M.D Supervising Physician Date

(2/2/11

Date

Any Borgman 055-0030098



November 21, 2011

ATTENTION: Amy Borgman

RE: Amy S. Borgman

To Whom It May Concern:

Amy S. Borgman is currently certified by NCCPA and holds NCCPA identification number 1011373.

NCCPA identification number 1011373 will remain valid until December 31, 2013. This PA was initially certified on January 15, 1983. However, this PA may or may not have been continuously certified during this time frame.

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

Sincerely,

Ciny Walls

Cindy Nalls

Manager of Certification Maintenance

P.S. You can verify the certification status of a PA by visiting our Web site at www.nccpa.net and clicking on Verify PA Certification.

The original version of this document includes NCCPA's raised seal, affixed above.



### Amy Borgman PA-C

Department of Health

Board of Medical Practice 108 Cherry Street - PO Box 70 Burlington, VT 05402-0070 healthvermont.gov [phone] 802-657-4220 [toll free] 800-745-7371 [fax] 802-657-4227



Date: January 10, 2012

Dear Physician Assistant:

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

			\$170 renewal fee								
Applicati	ón										
	Part	Л				Item 21					Item 39
			Item 1			Item 22					Item 40
			item 2	Part II					10*		Îtem 41
			Item 3			Item 23			همام م		Item 42
			Item 4			Item 24			•		Jtem 43A
			Item 5			Item 25					Item 43B
			Item 6			Item 26			C. Marie	d	Ttem 44A
			Item 7			Item 27			ob		Item 44B
			Item 8			Item 28					Item 45
			Item 9			Item 29					Item 46A
			Item 10			Item 30					Item 46B
			Item 11			Item 31					Item 47
			Item 12			Item 32					Item 48
		Item 13	Part III	·						Item 49	
			Item 14		닠	Item 33					Item 50
			Item 15			Item 34					Item 51A
			Item 16			Item 35					Item 51B
		Ų	Item 17			Item 36			Part V		·
			Item 18	Part IV		Item 37			•		Date
		Ц	Item 19	raitiv		Item 38					Signature
			Item 20		TOTAL STREET	item 50			•		
Child Su	ippor	t, Taxes,	Unemployment Compen	sation			Supervi	sing	Physician Fo	orms	
Stateme	nt								Primary Su	pervi	sing Physician Application
			Number 1 – check one of the two							ervising Physician	
			statements						Application	(s)	
			Number 2 – check one o statements	of the two			1		Delegation	Agre	ement
-	_		•				NCCPA	Cer	tification		
		-	ted form A ted Statement of Good St	anding					Proof of NC	CPA	Certification
777.1		( - <b>)</b> (			1	t					••

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

Thank you.

Enclosures



15000

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

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	nplete applications will	be returned. Attach	additional she	ets as needed.
Name in full	Theiler (Last)	Regan (First)	PANTE - PANTE	Nell (Middle)
Mailing Address _	23 Man	Office Name)	NC	(Middle) .
(City/State	` 1	Code)	803-( (Telephon	ne Number)
Vermont License #	1043-00123	764		
Hospital(s) where	you have privileges:	Hospital(s	s) Location	Specialty
Application	in process wr	th F.A.H.C		adoyn
What arrangements	s have you made for sup	pervision when you a		e or out of town:
or This DOCA outlining the scope of further certify that noting Section 1741.	practice, attached to this applice will be posted that a physic	Chapter 31, I shall be leg while under my supervision of exceed sician assistant is used, in	ally responsible form. I further certiful the normal limits accordance with	fy that the protocol
I further certify that I by (Ibate)	nave read the statutes and Bo	X	sician assistants.	)
	Co-si	gnature of PA:	2 h	Pr
Note: A PA who presc	ribes controlled drugs must	obtain an ID number from	m DEA. PA' DE	A Number <u>MB076</u> 333

3009E

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

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

APR 2 5 2011

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.
Name in full Tolvanen Kathleen Mone (Last) (First) (Middle)
Mailing Address — Panned Parenthood
103 laicott RD
(City/State) (Zip Code) (Telephone Number)
Vermont License #: <u>042-0012163</u>
Hospital(s) where you have privileges: Hospital(s) Location Specialty  PORSMOUTH REGIONAL HOSPITAL PORTSMOUTH, NH OBJEAN
What arrangements have you made for supervision when you are not available or out of town:
CERTIFICATE OF SUPERVISING PHYSICIAN
I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of HYYY, CYCHOY, P.A. while under my supervision. I further certify that the protocol of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.
further certify that I have read the statutes and Board rules governing physician assistants.  **Color: The Color: The Co
Co-signature of PA:  Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number 180763334

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomp	lete applications w	ill be return	ed. Attach	additional shee	ets as needed.
Name in full	Voveno	B	enec		
	(Last)	4	(First)		(Middle)
Mailing Address	Planned	Paren	thood		
	183 Tal	Coft r	Name) 2000		
	<u> Williston</u>	(Street)	3492	386	-8432
(City/State)	(Z	ip Code)		(Telephon	e Number)
Vermont License #:(	<u> 42-001119</u>	2			
Hospital(s) where you	ı have privileges:		Hospital(s)	Location	Specialty
MT. Ascutor	V HOSDITAL	11	und so	r vr	OBLAIN
DHMC	7	~ 1	eham	HU. 0	OBIENT
				7.	
List all physician's as		, , ,	•	Λ^ λ/	
		<u>उण्डमस्य द</u>		PALITUR!	(U), V).
Cotherine Nich		11	(1)	<u> </u>	VI
JAMEL YOU	) <del>\}                                    </del>	10	<u> </u>	11	<u> </u>
CERTI	FICATE OF SEC	CONDARY	SUPERVIS	SING PHYSIC	CIAN
I hereby certify that, in according to the consulted by the practice, attached to this a VSA, Chapter 31, Section	e aforesaid Physician Application, does not ex	only when the Assistant. I fur ceed the norma	primary supe ther certify that Il limits of my	rvising physician at the protocol ou practice and that	is unavailable and tlining the scope of
further ceptify that I have	read the statutes and J	Board rules go	erning physic	ian assistants.	
4/13/11		XK	Mei	RU	والمراجعة والمعادلة والمعا
(Date)		(Signature of	Secondary Suj	pervising Physici	an)

# PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete applications will	be returned. Attach ac	ditional sheets	as needed.
Name in full	Novello	Renee		Netschandon
	(Last)	(First)		(Middle) .
Mailing Address	Planned	Parenthoo	<u> </u>	
	6 Robert	(Office Name)		
The state of the s	Rutland	(Street) 05701	7775-23	333
(City/State)		Code)	(Telephone N	lumber)
Vermont License #:	042001195	•		
Hospital(s) where ye	ou have privileges:	Hospital(s) I	Location	Specialty
MT. ASCUTO DHMC	rey Hospital	Winds Lebanon,	orut.	OBLEYN
What arrangements	have you made for sup-	ervision when you are	not available or	out of town:
24/2 ON	Call Senice			
	CERTIFICATE OF	SUPERVISING PH	YSICIAN	·
outlining the soope of pr	accordance with 26 VSA, C COMO P.A. where the contraction of the cont	tile under my supervision. ication, does not exceed the	I further certify the	at the protocol
I further certify that I ha	ve read the statutes and Boa	urd rules governing physici	emal	·
	Co-sign	nature of PA:	J. 8.2	- PZ
Note: A PA who prescri	bes controlled drugs must o	btain an ID number from I	DEA. PA'S DEA N	ingsber <u>MB0N6</u> 3 <del>33</del> 34

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	mplete applications will be	returned. Attach addit	ional sheets as need	ed.
Name in full	Gibson (Last)	<u>Cheryl</u>	A	
	0) 1 0	(First)	(Mide	dle)
Mailing Address _	rianned tare	nthood		
	183 Talcott	Office Name) RD		
	WIIIISton, VI	Street) 05495	z88-843	32
(City/State)	) (Zip Coo	de) (	Telephone Number	)
Vermont License #	#: <u>0420001</u> 7465			
Hospital(s) where	you have privileges:	Hospital(s) Loca	ation Speci	alty
FAHC	BUMMAtor	),JT.	OBLE	yn_
Jahanna F	assistants names and addre MGN 90 WASHI fauser 23 Manst Ireth 6 Robert	esses you currently sup notion st. Bai Frid Ave. Bu S No. Rutland	me vt. Osk avnaton, vt. (	04/ 05401
CER	TIFICATE OF SECOND	ARY SUPERVISING	PHYSICIAN	(OVER)
only when consulted by practice, attached to this	accordance with 26 VSA, Chapped (CO), P.A. only we the aforesaid Physician Assistar is application, does not exceed the ion 1741, the use of a physician a	when the primacy supervising it. I further certify that the second limits of my practed from the practed in the primacy supervision in the	g physician is unavailab	ole and
further certify that I h	ave read the statutes and Board r	ules governing ohrysician as	ssistants.	
<u> </u>		ture of Sécondary Supervis	oing Physician)	



# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	mpiete applications v	vill be returned. A	ltach additional sh	eets as needed.	
Name in full	Novello	Rer	X66		
	(Last)	(First	<del>(</del> )	(Middle)	3 2010
Mailing Address _	Planned	. Parenthe	30d		
	6 Rober	ts North	e) į )		e etett – v. Assa,
	Ruttan	$\frac{1}{1}$ , $\frac{\text{(Street)}}{1}$	DI 1775-	- 9333	
(City/State	(Z)	Zip Code)	(Telepho	one Number)	
Vermont License	#: <u>042 001</u> 119	75			
Hospital(s) where	you have privileges:	Hosp	ital(s) Location	Specialty	
MT. ASCU Dertman	,	med ctr	asor, vt. Lebanon	OBGU	storyi
List all physician's	s assistants names an ロースター	d addresses you cu XNSHEIDAN		10, VT. 0546	
Thank the	West 1	Y	u J	\\	
<u>Catherine</u> N		<u> </u>	<u>\</u>	()	(5-0)
Sarah Vens	SC\ RTIFICATE OF SE	\lambda CONDADV SUDI		) / MATOTE	(NEK)
CEr	CHEICALE OF SE	CONDARI SUFI	ERVISING PH 13	DICIAN	
of And by only when consulted practice, attached to the	n accordance with 26 VS.  P.A.  the aforesaid Physician his application, does not extion 1741, the use of a physician physician physician in the second section 1741.	A, only when the prima Assistant. I further coexceed the normal limit	ary supervising physici ertify that the protocol ts of my practice and t	ian is unavailable a outlining the scope	nd e of
I further certify that I  (Date)	have read the statutes and	XXI	physician assistants.  On U  dary Supervising Phys	Marcian)	<u> </u>



# PRIMARY SUPERVISING PHYSICIAN APPLICATION

	(Last)		Jonna First)		(Middle)
Mailing Addres	s Planned	Paranthood	of NN	E	
128	Lakeside	Ave   (Office)			
<u>Burlin</u> (City/St	cton, VT	(Street) 05401 (Zip Code)	(*)	<b>802-44</b> Telephone N	8-9717 Jumber)
Vermont Licen	se #: <u>042, 00127</u> ;	29		,	
Hospital(s) who	ere you have privile Allon	ges: ]	Hospital(s) Loca Burlington	tion VT	Specialty Family
What arrangem	ents have you made	for supervision w	hen you are not	ilu Mac	out of town
What arrangem	ents have you made lantionship wi departments, they need ho	for supervision with UVM + F who will caused to spitalization	then you are not AHC Faw to for Aati	illy Mac unts in	out of town the ran
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What arrangem Shong Tell OBJGW instance  I hereby certify the of Amy be outlining the scope further certify that Section 1741.	ents have you made lantionship will be departments, they need ho CERTIFICA at, in accordance with 2 practice, attached to be practice, attached to be practice.	e for supervision with UVM + F who will can espitalization ATE OF SUPERV 6 VSA, Chapter 31, I , P.A. while under months application, does this application assistan	hen you are not  AHC For  to for Active  TSING PHYSI  shall be legally res y supervision. I fur so not exceed the not at is used, in accord	not available for all their certify the mal limits of ance with 26 v	the range of the state of the s

# SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incom	plete application:	s will be returned. Attach ac	ditional sheets as needed	
	Vovallo (Last)	Ronce		
	(Lagt)	(First)	(Middle	<del>)</del>
Mailing Address	Plannad	Parenthood of	Northern N	ew England
128	Lakeside		301	
Burlin (City/State)	gton	(Zip Code)	(Telephone Number)	-9719
Vermont License #:	042-0011	95		·
Hospital(s) where you Dortmouth	ou have privilege	s: Hospital(s) I	cocation Specialt	у <b>У</b>
Erin Haynes Anna Hildrat Tomiter Morian	h tv-lourn	24 Pannacook SL	St. Albans, VT osland, Ste 101, Top Autland, VT 057	<u>sham,</u> ME 04081 Ol
of Army borronly when consulted by practice, attached to this VSA, Chapter 31, Section	Accordance with 26 V ACCORDANCE AND ACCORDANCE APPLICATION, does not application, does not a 1741, the use of a	ECONDARY SUPERVISI VSA, Chapter 31, I shall be legally P.A. only when the primary supervian Assistant. I further certify that at exceed the normal limits of my physician assistant has been poste and Beard rules governing physician (Signature of Secondary Supervision)	responsible for all medical ac vising physician is unavailable the protocol outlining the sco- practice and hat in accordance d.	ctivities and



DEC 2 7 2013

Vermont Board of National Post line

December 23, 2013

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

RE: Amy S. Borgman

To Whom It May Concern:

Amy S. Borgman is currently certified by NCCPA and holds NCCPA identification number 1011373.

NCCPA identification number 1011373 will remain valid until December 31, 2015. This PA was initially certified on January 15, 1983. However, this PA may or may not have been continuously certified during this time frame.

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

Sincerely,

CINAY NAIIS

Cindy Nalls Manager of Certification Maintenance

P.S. You can verify the certification status of a PA by visiting our Web site at www.nccpa.net and clicking on Verify PA Certification.

The original version of this document includes NCCPA's raised seal, affixed above.



# Physician Assistant Delegation Agreement

#### Narrative:

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

### Supervision:

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

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

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

### Sites of Practice:

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

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

### Tasks/Duties:

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

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

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

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



# **Physician Assistant Delegation Agreement**

Manage routine DMPA problems.

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

MB 0763234
PA's VT DEA Number

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

Any 5 Borgman PA
Print Name

Signature

Date

Donna Burkett, MD

Collaborating Physician/Medical Director

Signature

1-9-14

Date

Renewal - 055.0030098 Page 1 of 11

### Renewal - 055.0030098

 Name
 Amy S. Borgman

 Credential
 055.0030098

 Fee Details

 Renewal
 \$170.00

 \$170.00

#### **Renewal Introduction**

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

Physician Assistant License Renewal

This application includes your Physician Assistant License Renewal Application. Please follow the instructions below and submit the completed application with uploaded documentation and credit card payment. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@state.vt.us. Your licensure will lapse if we have not received your completed application and fee by the due date.

#### **INSTRUCTIONS**

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

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

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

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

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

#### Please Note:

Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board. Thank you.

### Renewal Part I

1. Last Name:

Borgman

2. First Name:

Amy

3. Middle Name:

S.

4. All other names used:

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

Renewal - 055.0030098

5. Enter your MAILING ADDRESS information: **Attention** Street City State Country United States E-mail Address Telephone Alternate Phone (e.g. Pager) 6. Enter your PUBLIC ACCESS address information: Attention PPNNE Street 128 Lakeside Avenue **Zip** 05401 City Burlington State VT **Country** United States Telephone (802) 476-6696 E-mail Address Alternate Phone (e.g. Pager) 7. Date of Birth: 8. Birth City: 9. Birth State/Province: 10. Birth Country: 11. Select the certification examination taken (verification must be sent directly to this office from the Examining Agency): 12. Date NCCPA Examination was taken (if applicable): 13. Date VT Apprenticeship Examination was taken (if applicable): 14. Basis for Vermont Certification: 15. Do you have hospital privileges in Vermont? 16. List all hospitals where you have, or previously have had, privileges: **Facility Name** State Start Date 17. In what year did you start working as a physician assistant in Vermont?

- 18. Were you in active clinical practice in the past 12 months?
- 19. Other states where you either now hold an active certification or license or previously were certified or licensed to practice:

- [	State	Profession	License Number	Issue Date	Expiration Date	Status

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

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

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

	DO Supervisor	Relationship Type	Practice Location
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24. Has there been a change in your scope of practice which has not been reviewed by the Board?

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

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

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

### Renewal Part II

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

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

  No
- 28. State:
- 29. Year:
- 30. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:
- 31. Denied certificate to practice medicine or any other healing art Upload documents
- 32. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art?

  No
- 33. State:
- 34. Year:
- 35. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:

36. Withdrawal or denial of license or certificate - Upload documents:
37. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?  No
38. State:
39. Year:
40. Circumstances:
41. Voluntary surrendered or resigned a license or certificate to practice medicine or any healing art - Upload documents:
42. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
43. Name of organization involved:
44. Date:
45. Duration:
46. Action Taken (add all that apply):
47. Circumstances:
48. Disciplinary charges or actions - Upload documents:
49. Have you ever been denied the privilege of taking an examination before any state medical examining board? No
50. State:
51. Circumstances under which examination privileges denied:
52. Denial of examination privileges - Upload documents:
53. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education? Yes
54. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued: 4 month leave of absence after birth of children, 12/90 to 4/91 and 6/92 to 10/92
55. Discontinued Education, Training, or Clinical Practice - Upload documents:
56. Have you ever been dismissed or suspended from, or asked to leave a training program before completion? No
57. Training program(s):

58. Location of program(s):
59. Year:
60. Circumstances:
61. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?  No
62. Institution involved:
63. Location:
64. Year:
65. Circumstances:
66. Affecting health care institution staff privileges, employment or appointment - Upload documents:
67. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?  No
68. Name of organization involved:
69. Type of restriction:
70. Date:
71. Circumstances:
72. Privilege to prescribe controlled substances - Upload documents:
73. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice. No
74. Please provide a general description of your practice of internet prescribing:
75. Are you presently, or have you ever been, a defendant in a criminal proceeding? No
76. Court:
77. City and state:
78. Charge:

79. Description:
80. Status:
Renewal Part III
(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)
Any "yes" response to the questions below must be fully explained.
81. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?
82. Licensing or certification board:
83. Date:
84. Location of Licensing Board:
85. Circumstances:
86. Investigation by other licensing or certification board - proceeding - Upload documents
87. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?
88. Court:
89. City and state:
90. Charge:
91. Description:
92. Status:
93. Date:
94. Criminal Investigation - proceeding - Upload documents
MEDICAL QUESTIONS
Please answer "Yes" or "No" to the questions below. Definitions are provided to assist you in answering. Please explain any "Yes" answers.

**DEFINITIONS** 

In answering the following questions, please use these definitions:

#### "Ability to practice medicine" - This term includes:

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



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



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

#### **IMPORTANT**

Renewal - 055.0030098 Page 8 of 11

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

#### Renewal Part IV

#### **Statutory Profile Questions**

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

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

No

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

Date of Conviction	Court of Conviction	Citv	State	Description

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

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

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

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

Date of Charges	Court	City	State	Description of Charges

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

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

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

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

	_	•	,,	•	,	· • •	
Da	te			Final Disposition Sum	mary		

110. 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?

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

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

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

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

113.

A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or

Renewal - 055.0030098 Page 9 of 11

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
Date of Restriction	i iospitai ivailie	State	Mature of Nestriction	iveason for ivestriction

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

Nο

115

### B. Other Restrictions

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

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

116. <u>Medical Malpractice Court Judgments/Settlements</u> [See 26 VSA § 1368(a)(6A)] Have you ever been involved in a Malpractice Liability Claim? Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Nο

117.

#### A. Judgments

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

Date of Judgment

118

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

Date Of Settlement

#### **Medical Malpractice Claim**

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

#### 119. Years of Practice

What year did you start practicing as a medical professional? 1982

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

	Facility Name	City	State	Start Date	End Date
--	---------------	------	-------	------------	----------

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

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

121.

#### A. Appointments

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

School	City	State	Nature of Position	Date Started	Date Ended
University of Vermont	Burlington	Vermont	Adjunct Professor	06/01/2009	12/01/2011

122

#### B. <u>Teaching</u>

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

School / Institution	City	State	Nature of Teaching	Date Started	Date Ended
University of Vermont	Burlington	Vermont	Preceptor	06/01/2004	12/01/2011

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

Renewal - 055.0030098 Page 10 of 11

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

Title Publication Publication Date

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

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

Activity or Award

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

Practice Name	City		Primary Practice	Languages		Accepts New Medicaid Patients?
PPNNE	Burlington	Vermont	Yes		Yes	Yes
Planned Parenthood of Northern New England	Barre	Vermont	Yes		Yes	Yes

### **Statement of Good Standing**

126.

# State of Vermont Department of Health Board of Medical Practice

#### Statement of Good Standing

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

I hereby state that either:

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

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

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

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

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

Yes

127. Date:

12/22/2013

### Statement Regarding Child Support, Taxes

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

#### APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed

unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

128. You <u>must</u> select one of the two statements below regarding child support regardless whether or not you have children: I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

#### Regarding Taxes

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

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

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

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

130. Social Security Number:



131. Date of Birth:



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

Yes

133. Date: 12/22/2013

#### **Workforce Survey**

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

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

#### **Renewal Payment**

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

Credit Card

#### Review

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE TWO OF FIVE

13. Do you have hospital privilege Name(s) and Location(s) of Hospi	s in Vermont? Yes tal(s):	No
14. Did you predice if Vermont do		
15. Other states Where you now had states where you previously w	old an active certification over certified or licensed to	or license to practice:
17. Specialty: G		DEA Number:
to. Name and office address of	current employer:	•
Name	Addres	SS
PPNNE	<u> </u>	WASHINGTON ST BARRE UT 05641
19. Name, specialty and office a Name	ddress of Supervising Pl Specialty	hysician(s): Address
Judy Typon MD	Cyn	GO PPUDE 23 HANSFIELD AVE
20. Name, specialty and office a Name	ddress of the Secondary Specialty	Supervising Physician(s): Address
Cheryl Gibson MD	GUN	do women's efforce 23 mussisco AVE
		BURC UT 05401

- 21. Please attach a copy of your NCCPA certificate.
- 22. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. a) Has your scope of practice changed? Yes No b) Please review, sign and date (include all parties) your scope of practice. c) Please attach a copy of your signed scope of practice.
- 23. Documentation showing practice as a Physician's Assistant within the past twelve months: Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician's Assistant within the past twelve months.

An applicant for certification renewal who has not practiced as a Physician's Assistant for more than twelve months must submit a satisfactory evaluation by the Supervising Physician prior to renewal.

# 24. Continuing Medical Education (CME) requirements:

- a. NCCPA certified Physician's Assistants: Attach proof of recertification; this will serve as adequate proof of CME completion.
- b. For all others, enclosed please find an explanation of requirements and a logging form. If you have any questions, please address them in writing to Board Member Jack Cassidy, P.A. at the Board's address.
- 25. All Physician's Assistants are required to have a Secondary Supervising Physician for their practice. We have enclosed a form to be returned to this office if you do not have a Secondary Supervising Physician on file with our office.

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE THREE OF FIVE

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

T. Have you ever had any organic illness, emotional disturbance or mental illness which has impaired your ability to practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, residently to the practice as a physician's assistant or to function as a physician's assistant student, and the physician are proportional physician as a physici
2. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
3. Are you currently under investigation for a criminal act?
4. Are you now, or have you been in the past, dependent upon alcohol or drugs?
5. 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 physician's assistant association (international, national, state or local)?  YESNO
6. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)?
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a medical staff after a complaint or peer review action has been initiated against you?
8. Have you ever voluntarily surrendered or resigned a license to practice as a physician's assistant or any healing art?
9. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? YES VES NO
10. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?YESNO
11. Have you ever withdrawn an application for physician's assistant certification or license, or been denied a physician's assistant certification or license for any reason?
12. Have you ever been turned down for coverage by a malpractice insurance carrier?YESNO
13. Have you ever been notified as a responsible party of a Severity Level III quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont orYESNO
14. To your knowledge, are you the subject of an investigation by any other licensing beard as of the data of this application?
15. Have you ever been dismissed or asked to leave from a residency training program(s)  Operore completion?  YES  NO

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FOUR OF FIVE

# SECTION III

(Month/Year)	ate you starte 7 /86	ed practicing	as a physician's	assistant in	Vermont (exclud	ing residend	cy training)?	
Instructions for practice. Be as o	<b>completing</b> letailed as po	<b>the next p</b> ossible. Est	ortion: Please of imate if exact fig	omplete one ures are not	site" section for available.	each locatic	on where you	
The codes to be at one practice	e used for th site):	ie Employn	nent Setting col	umn are as	follows (If applic	able, list m	ultiple codes	
1 Solo Practice	,	6 HM	O (Health Mainte	nance Orga	nization) 11 Teac	hina		
2 Group Practice		7 Ext	ended Care Faci	lity	12 Othe	r Specify:	Planua Parent	h. 0 -
3 Community He			nool/College Heal			·	Family Plann	
4 Hospital Outpa			cupational Health				(	5
5 Hospital Inpati	∍nt	10 Er	nergency Room				,	
4. Practice Site	Number On							
Street Address:		3 BHINGTON	> 9t					
Town:				7ip: 0564	1			
	12010-0	<u> </u>		.ip. <u>-0.384</u>				
	Hours per	Employment	Will the practice of	Wlit you	What percent of	Will you	What percent of	Will you
	week engaged	Setting (See	this specialty be	accept new	the patients in	accept new	the patients in	accept ne
_	in direct	codes	discontinued within the next 12 months?	patients in this apacialty?	this specialty are funded by Medicaid?	Medicaid petients	this specialty are funded by Medicare?	Medicare petients
Specialty	petient care	on Page 4.)	(Yes or No)	(Yes or No)	(Estimate if necessary.)	in this	(Estimate if	in this
mila Plannina	7-15	12	No	Yes	~30%	specialty?	necessary.)	specialty?
THE	1-10	ļ	1 100	7 25	206	Yes	<1.1°	Y-63
V								
		].						
				€ <sup>c</sup>	/	.*		·
Check the financ	ial organizati	on which be	st describes this	site;	For-profit V	Vonorofit		
Check the financ	ial organizati	on which be	est describes this	site:	For-profit	Nonprofit	***************************************	
Check the financ	ial organizati	on which be	est describes this	site:	For-profit	Vonprofit		
			est describes this	site;	For-profit	Nonprofit		
5. Practice Site	Number Two	)	st describes this	site:	-	,		
	Number Two	)	est describes this	site:	For-profit	,	Zip; <u>0 5</u> 06	>
5. Practice Site	Number Two Q( 'S. M	employment	Will the practice of	site:	Town: Rappi	→o∠PK Will you	Zip: 0506	Will you
5. Practice Site	Number Two 4 ( 'S. M  Hours par week angaged	) ain 34	Will the practice of this specialty bs	Will you accept new	Town: Rappi	₩ill you accept new	What percent of the patients in	Will you accept nev
5. Practice Site Street Address;	Number Two 4 ( 'S. M  Hours par week engaged in direct	Employment Setting (See codes	Will the practice of	Will you accept new petients in this specialty?	Town: Rapi	₩ill you accept new Medicaid patients	What percent of the patients in this specialty are funded by Medicare?	Will you
5. Practice Site Street Address: _ pecialty	Number Two 4 ( 'S. M  Hours par week angaged	Employment Setting (See	Will the practice of this specialty be discontinued within	Will you accept new petients in	Town: Ra poi What percent of the patients in this specialty are funded by Medicaid? (Estimate if	≫ο∠Ρ∱ Will you accept new Medicaid patients in this	What percent of the patients in this specialty are funded by Medicare? (Estimate if	Will you accept new Medicare patients in this
5. Practice Site Street Address;	Number Two  4 ( '3. M  Hours par  week engaged in direct patient	Employment Setting (See codes	Will the practice of this specialty be discontinued within the next 12 months?	Will you accept new petients in this specialty?	Town: Rapi	₩ill you accept new Medicaid patients	What percent of the patients in this specialty are funded by Medicare?	Will you accept nev Medicare patients

# SECTION IV: STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FIVE OF FIVE

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

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

for perjury is fifteen years in prison, a \$10,000 fine, or both.
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT
I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due as of the date of this application.  OR
I hereby certify that I an NOT in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship" to the address below.
APPLICANT'S STATEMENT REGARDING TAXES
I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000 fine, or both)
OR
I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship" to the address below.
STATEMENT OF APPLICANT
I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary action.
Social Security Number:
The disclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405(c)(2)(C), and will be used by the Department of Taxes in the administration of Vermont tax laws, to identify individuals affected by such laws.
Date: 1.24.94 Signature:
Return the completed form and fee to:  (Return envelope enclosed)  Vermont Board of Medical Practice  109 \$tate Street
Montpelier, Vermont, 05609-1106

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

IMPORTANT: Please be sure to write your certification number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of \$55.\* in check or money order payable to the Vermont Board of Medical Practice.

(Medical Board Renewal Fee: \$50. + Office of Professional Regulation (OPR) Fee: \$5.00 = \$55. OPR's \$5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

\*Note: Physician's Assistants 80 years of age or older are exempt from payment of a renewal fee; however the Physician's Assistant certification renewal application must be completed and submitted.

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

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE ONE OF SIX

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

Your Name: A Mu	SBORGM	W	
Insurer: Planned Protect	ction Insurance	LCo, Ltd.	
Claimant Name: U 4	a Whipple		
	) of Claim (Allegations	Only: This does not constitute an	
Basis Code: 0 9	Basis Code:		
Basis Code:	Basis Code:		
Additional Descriptive Informati  1) Patient's condition at point of y.  2) Patient's condition at end of tre  3) The nature and extent of your i  4) Your degree of responsibility fo	our involvement; atment; nvolvement with the pati	ent; and in leading to the claim.	
		c'	
If the incident resulted in patien	t's death, indicate caus	e of death according to autopsy o	or patient chart:
PLEASE NOTE: Submission of co	pies of pertinent medical	records will be necessary in some	instances.
Incident Location (circle one): 01 Emergency Room 05 Outpatient 09 HMO 13 Walk-In Center	02 Labor/Delivery 06 Patient Room 10 Clinic 14 Other	03 Laboratory/X-Ray/Testing 07 Hospital-Other 11 Nursing Home 15 Unknown	04 Operating Room 08 Hospital-Unknown 12 Physician's Office

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE TWO OF SIX

# SECTION A: MEDICAL MALPRACTICE CLAIM CONTINUED

Your Role (circle one):		
01 Anesthesiologist	11 PGY 4	
02PA Physician's Assistant	12 PGY 5	
03 Referring Physician	13 PGY 6	
04 Attending Physician	14 PGY 7	
05 Consultant Specialist	15 Workmen's Compensation Evaluator	
06 Surgeon	16 Court Psychiatrist	
07 Fellow	17 On-Call Physician	
08 PGY 1	18 Group Practitioner/Partner	
09 PGY 2	19 Other: Specify	
10 PGY 3	20 Unknown	
	ame, address and telephone number):	
	innett I	
	UK & Callins Inc	
	9.A	<b>~</b>
City State Zin: Ruby	TON N 05402	
Telephone Number: ( 802 )	658-0042	
Indicate Decision, Appeal, Sett		
If the Court has heard your case,	indicate the following:	
Decision determined by (Check of	ne): Judge Jury	
Decision:	Award:	_
If your case was appealed, indica Date Appeal Decided:/	ate the following: Date Appeal Filed (Month, Day, Year)	
If your case was settled, indicate	the following:	
Settlement amount paid on your	behalf:	
Total settlement amount:		
Date of Settlement: (Month, Day,	Year) / /	
	•	
Case dismissed against yo	ou Against all defendants	
Important: In addition to the a settlement and release, or other representative.	bove information, please attach a copy of the comp final disposition of the claim. This information can be	laint and final judgment obtained from your lega
Additional information, if any:	•	
	ise is pending	
	Table I for Section A on the next page	

Re: Amy S. Bryman. # 55-0030098 A

I was a physician's assistant at Planned Parenthood of Northern New England in March 1989 when the claimant, Nyra Whipple came to our outpatient clinic for an annual exam. In the course of my examination of her breasts, I noted an area of what I believed to be fibrocystic changes. I ordered a routine baseline mammogram for her which was mandated by her protocols. The mammogram report showed no cancer, but the radiologists questioned the need for correlation of asymmetrical density seen on the mammogram with the clinical findings. The radiography report was discussed with the Medical Director of Planned Parenthood, Judith Tyson, M.D., who after discussing my findings with me advised that the patient should have repeat mammography at one year.

Repeat annual exam of the breasts and repeat mammography in the following year showed only fibrocystic changes and no cancer.

Almost two years after my exam, at her next annual exam, the patient was noted to have a lesion consistent with cancer. The lesion was biopsied and cancer was found. In a lawsuit against my employer, Planned Parenthood of Northern New England, plaintiff is apparently claiming my care, as well as that of Dr. Tyson and the other provider, a Nurse Practitioner, was substandard.

Plaintiff had a mastectomy and treatment with chemotherapy and, to the best of my knowledge, is alive and well.

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE THREE OF SIX TABLE I - BASIS CODES - ALLEGATIONS ONLY

TABLE I - BASIS CODES -	ALLEGATIONS ONLY
DIAGNOSIS RELATED	Improper Treatment: Medication Related
D01 Delay in Diagnosis	T21 Failure to obtain informed consent/exceeding consent obtained
Esilure to Diagnose:	T22 Failure to take adequate patient history
002 Abdominal Problems (other than appendicitis or ulcer)	T23 Failure to diagnose drug related problem(s) (other than addiction)
D03 AIDS/AIDS Related Complex	T24 Failure to diagnose drug addiction
DO4 Allergy	T25 Prescribing to a known addict
D05 Appendicitis	T26 Wrong medication ordered
D06 Arthritis	T27 Wrong dose of medication ordered
D07 Bladder Problem	T28 Improper route of administration
D08 Bowel Problem	,T29 Drug side effect
D09 Breast Cancer	T30 Failure to prescribe
D10 Cancer (other than breast)	T31 Drug toxicity/overdose
D11 Cardiac Disorder/Illness/Problem (not myocardial infarction)	T32 Other Specify:
D12 Circulatory Problem	
D13 Diabetes	Improper Treatment: Mental litness Related
D14 Fracture/Dislocation	T33 Failure to obtain informed consent/exceeding consent obtained
D15 Gall Bladder Disorder	T34 Failure to diagnose mental disorder/illness/problem
D16 Genetic Disorder	T35 Improper medication prescribed
D17 Hemorrhage	T36 Improper commitment
D18 Hernia	T37 Improper discharge
D19 Implanted Foreign Body	T38 Improper monitoring.
D20 Infection	T39 Improper use of seclusion/restraints
	T40 Suicide/Suicide attempt by inpatient
D21 Kidney Disorder	T41 Suicide/Suicide attempt by outpatient
D22 Liver Disorder	T42 Other Specify:
D23 Meningitis	142 Office Opochy.
D24 Myocardial Infarction	Impressor Treatments Chatching Congressors Deleted
D25 Neurological Disorder	Improper Treatment: Obstetrics-Gynecology Related
D26 Orthopaedic Problem (other than fracture/dislocation)	T43 Failure to obtain informed consent/exceeding consent obtained
D27 Pneumonia/Pneumothorax	T44 Failure to diagnose pregnancy, normal
D28 Poisoning	T45 Failure to diagnose pregnancy related problem
D29 Respiratory Problem	T46 Failure to diagnose ectopic pregnancy
D30 Tendon Injury	T47 Failure to diagnose endometriosis
D31 Thrombosis	T48 Failure to diagnose fetal distress
D32 Turnor	T49 Failure to identify mother-fetus blood problem
D33 Ulcer or Complication(s) of Ulcer	T50 Improper performance of abortion
D34 Other Specify:	T51 Improper management of pregnancy
	T52 Improper management of delivery
D35 Failure to Obtain Consent for Diagnostic Procedures/Exceeding consent obtained	T53 Improperly performed vaginal delivery
D36 Misdiagnosis	T54 Improperly performed C-section
D37 Ordering/Performing Unnecessary Diagnostic Tests/Procedures	T55 Delay in performing C-section
D3B Failure to Perform Diagnostic Test(s)	T56 Delay in treating fetal distress
D39 Other Diagnosis Related Injury	T57 Failed sterilization
way a final prompt to the miles	T58 Wrongful life/birth
EQUIPMENT	T59 Fefal death/stillborn
E01 Equipment: Misuse	T60 Maternal death related to delivery
E02 Equipment: Malfunction	T61 Other Specify:
E03 Equipment: Other Specify:	Total opening.
Edo Equiphiant. Other Specify.	Improper Treatment: Surgery Related
WANDANCO TOCATHENT	to the second se
IMPROPER TREATMENT	T62 Failure to obtain informed consent/exceeding consent obtained
TO1 Delay in Treatment	T63 Improper performance
T02 Failure to Obtain Informed Consent/Exceeding Consent Obtained	T64 Failure to diagnose post-operative complications
T03 Improper Choice of Treatment	T65 Improper treatment of post-operative complications
T04 Infection	T66 Retained foreign bodies (e.g. needle, sponge, instrument, etc.)
T05 Fracture/Dislocation	T67 Delay in surgery
T06 Chronic Vegetative State Resulting from Medical Intervention	T68 Unnecessary surgery
	T69 Wrong body part
Improper Treatment: Anesthesia Related	T70 Laceration or penetration not within scope of surgery
T07 Failure to obtain informed consent/exceeding consent obtained	T71 Death in the course of/resulting from surgery
T08 Failure to take adequate patient history	T72 Other Specify:
T09 Failure to monitor	
T10 Failure to test equipment/improper use of equipment	Improper Treatment: Specified Procedures
T11 Improper intubation	T73 Angiography
T12 Improper positioning	T74 Arteriography
T13 Wrong amount/type of anesthesia prescribed	T75 CAT scan
T14 Allergic/adverse reaction	T76 Catherization
-	T77 Colonoscopy
T15 Teeth damage	
T16 Other Specify:	T78 Cryosurgery
TELNOTHOLON	T79 Discogram
TRANSFUSION	T80 Electroconvulsive Therapy
TR17 Mismatch	T81 Endoscopy
TR18 Caused AIDS	T82 Esophageal Dilatations
TR19 Caused Hepatitis	T83 Injection/Immunization
TR20 Other Specify:	T84 Laparoscopy
	T85 Lasers, used in treatment
•	T86 Myelography

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FOUR OF SIX

# SECTION B: CRIMINAL PROCEEDING - ATTACH DOCUMENTS Court: \_\_\_\_\_ Charge: \_\_\_\_ Date: \_\_\_\_ Description: Conviction?: \_\_\_\_\_ Date: \_\_\_\_ Plea?: \_\_\_\_\_ SECTION C: DISCIPLINARY CHARGES OR ACTION - ATTACH DOCUMENTS Name of Organization Involved: \_\_\_\_\_\_ Date: \_\_\_\_\_ Duration: Action Taken (circle all that apply): 12 Leave of absence 01 Revocation of right or privilege 13 Withdrawal of an application 02 Suspension of right or privilege 14 Termination or non-renewal of contract 03 Censure 15 Medical Records Suspension 04 Written reprimand or admonition 16 Probation 05 Restriction of right or privilege 17 Assurance of Discontinuance 06 Non-renewal of right or privilege 18 Consent Agreement 07 Fine 08 Required performance of public service 19 Letter of Agreement 20 Expulsion from Membership 09 Education/Training/Counseling/Monitoring 21 Reprimand 10 Denial or right or privilege 22 Other Specify: 11 Resignation Circumstances: SECTION D: PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES - ATTACH DOCUMENTS Name of Organization Involved: Type of Restriction: \_\_\_\_\_\_ Date:\_\_\_\_\_ Circumstances of restriction:

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FIVE OF SIX

SECTION E. WITHDHAWAL OR DENIAL OF	F LICENSE OR CERTIFICATION- ATTACH DOCUMENTS
State:	Year:
terminated):	ation was withdrawn or denied (revoked, not renewed, or otherwise
	HER LICENSING BOARD - ATTACH DOCUMENTS
	Date:
Circumstances:	
SECTION G: RESIDENCY TRAINING PROC	GRAM(S) NOT COMPLETED - ATTACH DOCUMENTS
Lessing of Drawn (s):	
	Year:
SECTION H: TREATMENT FOR EMOTION ALCOHOL OR DRUG DEPENDENCY	NAL DISTURBANCE OR MENTAL ILLNESS, ORGANIC ILLNESS
Treating Organization:	
Telephone: ()	The state of the s
Type of Condition and Treatment:	
Dates of Illness/Dependency:	to
Dates of Treatment:	

# STATE OF VERMONT - BOARD OF MEDICAL PRACTICE FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE SIX OF SIX

A LIACH DOCUMENTS	RE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMEN
Date:	
Circumstances:	
SECTION J: VOLUNTARILY SURREN A PHYSICIAN'S ASSISTANT OR ANY	DERED OR RESIGNED CERTIFICATION OR LICENSE TO PRACTICE AS HEALING ART - ATTACH DOCUMENTS
State:	Year:
	RTICIPATE OR ENROLL - THIRD PARTY PAYER - ATTACH DOCUMENTS
Third Party Payer:	Year:
	ŕ
SECTION L: TURNED DOWN FOR	COVERAGE BY MALPRACTICE INSURANCE CARRIER - ATTACH
Malpractice Insurance Carrier:	Year:
SECTION M: SEVERITY LEVEL III NOT	TICE BY PEER REVIEW ORGANIZATION (PRO) - ATTACH DOCUMENTS
	Year:

# National Commission on Certification of Physician Assistants, Inc.

NCCPA requires certificate reregistration, which includes 100 hours of continuing medical education, every two years in order to maintain certification.

This verifies that:

AMY S. BORGMAN

Has met the requirements and is reregistered.

Certificate No.

830420

Expiration Date: JUNE 1, 1995

Executive Vice President and Managing Director

This verification extends the validity of the NCCPA certificate until the indicated expiration date, and is only valid when accompanied by

THE ABOVE VERIFICATION OF REREGISTRATION VALIDATES THE NCCPA CERTIFICATE FOR THE NEXT TWO YEARS.

IF ANY INFORMATION ON THIS VERIFICATION IS INCORRECT, PLEASE CONTACT NCCPA,

830420 AMY S. BORGMAN

NATIONAL COMMISSION CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

BORGMAN

has met the requirements for certification and is entitled to use the designations

PHYSICIAN ASSISTANT-CERTIFIED and PA-C

Certificate No,: Expiration Date:

and Managing Director

This card is for identification purposes only and does not constitute proof of certification. For verification, please contact NCCPA.

47535-93



# American Academy of Physician Assistants

950 N. Washington Street, Alexandria, VA 22314-1552 Phone Number: 703/836-AAPA (2272)

CONTINUING MEDICAL EDUCATION REPORT



vTULATIONS. Our records indicate you have earned and reported to AAPA 100 CME hours (at least 40 in Category I) to update your NCCPA certificate. As a service to its certified members members who purchase the service) the AAPA has notified the National Commission on Certification of Physician Assistants that you have completed the CME requirement for updating JPA certificate for the current two-year period.

Hours

JUNE 2, 1993 (PERIOD 6/91 - 6/93).

MS. AMY S. BORGHAN PA-C

Hours logged to date for this reregistration

reregistration period

Hours remaining

to log for this

CATEGORY I

48

CATEGORY II



802 • 878-7232 FAX 802 • 878-8001

SERVING MAINE, NEW HAMPSHIRE & VERMONT

January 26, 1994

Vermont Secretary of State's Office Board of Medical Practice Pavilion Office Building Montpelier, Vermont 05602

To whom it may concern:

Enclosed is a Physician's Assistant Certification Renewal Application for Amy Borgman and a check for the renewal fee.

I believe that she has a copy of a Secondary Supervising Physician Application on file with you. Please let me know if you are missing it for Amy.

I believe that you also have a copy of our medical protocol on file.

Please contact me if I can be of further assistance to you as you process these applications. Thank you.

Sincerely,

Valerie Wilkins

Assistant to the Associate Director

### 51 Talcott Road, #1 Williston, VT 05495



802 • 878-7232 FAX: 802 • 878-8001

### SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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January 10, 1994

Vermont Secretary of State's Office Board of Medical Practice Pavilion Office Building Montpelier, Vermont 05602

To whom it may concern:

Amy Borgman has practiced as a Physician's Assistant in the last twelve months. She will be working with Planned Parenthood of Northern New England's (PPNNE's) Medical Protocol under my supervision. Copies of PPNNE's Medical Protocol and Standing Orders are on file with you.

Please contact me if I can be of further assistance to you as you process her application. Thank you.

Sincerely,

Judith Tyson, M.D.

Medical Director, PPNNE

Date Effective: January 1993

The Family Planning Practitioner may:

- A. Provide information and counseling on: family planning methods, sterilization, unintended pregnancy, and options; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.
- B. 1) Order and dispense oral contraceptives in accordance with the PPNNE Medical Protocol.

Manage routine oral contraceptive problems.

- Order special laboratory tests needed to prescribe oral contraceptives to patients with special risk factors.
- C. 1) Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol.

2) Manage routine Norplant problems.

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

Manage routine IUD problems.

- 3) Order X-rays and sonograms for IUD localization.
- E. 1) Fit and check diaphragms, cervical caps and sponges in accordance with the PPNNE Medical Protocol.
  - Manage diaphragm, cervical cap and sponge problems.
- F. 1) Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol.
  - 2) Manage condom and spermicide problems.
- G. Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical mucus and calendar.
- H. Evaluate patient history and laboratory data and perform elementary physical examination and pelvic examination in accordance with the PPNNE Medical Protocol.
- I. Administer parenteral medications in accordance with the PPNNE Medical Protocol. These medications specifically are:

Atropine
Benadryl
Ceftriaxone
Depo-medroxyprogesterone acetate
Diazepam
Epinephrine
Gentamicin
Hepatitis B vaccine

Lidocaine
Penicillin
Pitocin
Progesterone
Rh immune globulin
RhoGam
Rubella vaccine
Spectinomycin
Streptomycin

J. Order and dispense the following oral medications in accordance with PPNNE Medical Protocol:

Acetaminopen (Tylenol)
Acyclovir (Zovirax)
Amoxicillin
Ampicillin
Anaprox
A.S.A.
Azithromycin
Benadryl
Cefixime
Ciprofloxacin
Conjugated estrogens (Premarin)
Doxycycline
Erythromycin
Estradiol (Estrace)

Ibuprofen (Motrin, Nuprin, Advil) Macrodantin Medroxyprogesterone acetate (Provera) Mefenamic acid (Ponstel) Methergine Metronidazole (Flagyl) Naproxen sodium (Anaprox) Nicorette gum Norfloxacin Nystatin Ofloxacin Probenecid Pyridium Pyridoxine (Vitamin B6) Sulfizoxazole (Gantrinsin) Tetracycline Trimethoprim-sulfamethoxazole (Bactrim, Septra)

Fenoprofen (Nalfon)

Ferrous Fumarate

Ferrous Sulfate

Ferrous Gluconate

K. Order, dispense and use the following topical medications in accordance with the PPNN'E Medical Protocol:

Acigel
Acyclovir cream (Zovirax)
Ammonia inhalant
Betadine vaginal preparations
Butoconazole nitrate cream 2%
 (Femstat)
Clindamycin vaginal cream
Clotrimazole cream, suppositories
 (Mycelex, Gyne-Lotrimin)
Condylox topical solution
Crotamiton cream/lotion (Eurax)
Estrogen patches
Metronidazole vaginal gel
 (Metro Gel)

Miconazole cream, suppositories
(Monistat)
Monsell's solution (Ferric
subsulfate)
Nicotine patches'
Nystatin suppositories, tablets
Podophyllin (various formulations)
Synthetic pyrethrins (A-200, RID)
Terconazole vaginal suppositories (Terazol)
Trichloroacetic acid
Triple Sulfa creams, suppositories
(Sultrin)
Vagisec douche, suppositories
Xylocaine gel, ointment

- L. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.
- M. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test and titers.
- N. Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well child and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.
- O. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.
- P. Perform venipuncture; start and maintain I.V.'s.
- Q. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.

The Family Planning Practitioner must:

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

Collaborating Physician: Judith Tyson, M.D., Medical Director, PPNNE

I agree to practice under the above standing orders

Signature Date 1.20.93