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.

055-0030098

Amy S. Borgman PA-C
Planned Parenthood of Northern N.E.
90 Washington Street
Barre, VT 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: Amy S. Borgman 2. Vermont Certification Number: 55-0030098

3. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere: N/A

4. Home Address: [redacted]

City, State, Zip Cod[redacted]

5. Office Address: 90 WASHINGTON ST

City, State, Zip Code: BARRE VT 05641

6. Daytime Telephone Number: Area Code: (802) 476-6676

7. Date of Birth: Month: [redacted] Day [redacted] Year [redacted]

8. Place of Birth: [redacted] 9. Sex: ___ Male ___ Female

10. Certification Examination Taken - Check: ✓ NCCPA ___ State Examination-Identify State: ___
___ Other Examination Specify: ___

11. Basis for Vermont Certification: ___ Apprenticeship Trained
✓ University Trained

12. Undergraduate Degree - Circle: B.A. (B.S.) A.B. Other: ___ Year of Graduation: 1982

Degree Granting Institution: GWU
Location: WASH DC
First Institution (If transfer): ___ Location: ___

P.A. Diploma or Certificate: BS 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? ____ Yes ✓ No
Name(s) and Location(s) of Hospital(s): _____

14. Did you practice in Vermont during the past 12 months? ✓ Yes ____No

15. Other states where you now hold an active certification or license to practice: Ø
16. States where you previously were certified or licensed to practice: VA

17. Specialty: GYN DEA Number: VIA

18. Name and office address of current employer:

Name	**Address**
PPNNE - 90 WASHINGTON St	Barre VT 05641

19. Please review the attached list of current Primary and Secondary Supervising Physicians. Is the information correct? ✓ Yes ____ No if no, contact the Board. If no list is attached, please fill out the information below:
Name, specialty and office address of Supervising Physician(s):

Name	**Specialty**	**Address**

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, 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 ✓ 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 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
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:

1. Have you 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, resident or apprentice? [redacted]

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

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

4. Have you been dependent upon alcohol or drugs?

5. Are any formal disciplinary charges pending or has any disciplinary action 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)? ____ YES ✓ NO

6. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? ____ YES ✓ NO

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

8. Have you voluntarily surrendered or resigned a license or certification to practice as a physician's assistant or any healing art in lieu of disciplinary action? ____ YES ✓ NO

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

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

11. Have you withdrawn an application for physician's assistant certification or license, or been denied a physician's assistant certification or license for any reason? ____ YES ✓ NO

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

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

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

15. Have you been dismissed or asked to leave a residency training program(s) before completion? ____ YES ✓ 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 have children:

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

or

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

Applicant's Statement Regarding Taxes

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

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

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

or

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

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

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 403 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

Statement of Applicant

I further certify that all the 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.

Signature of Applicant [signature] Date 12.12.95

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

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

Questions?: (802) 828-2673

Important: Please be sure to write your 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.**

National Commission on Certification of Physician Assistants, Inc.

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

830420
AMY S. BORGMAN
[redacted]

NATIONAL COMMISSION
ON
CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

AMY S. BORGMAN
has met the requirements for certification and is entitled to use the designations

PHYSICIAN ASSISTANT-CERTIFIED *and* **PA-C**

Certificate No.: 830420
Expiration Date: 06/01/97

Executive Vice President and Managing Director

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
(Last) (First) (Middle) (Former)

Mailing Address Women's Choice Gynecologic Associates
(Street) (City)

23 Mansfield Ave. Burlington, VT 05401 863-9001
(State) (Zip Code) (Phone)

Office Address same as above
(Street) (City)

(State) (Zip Code) (Phone)

Vermont License # 42-0007465 Number of years you have been practicing Medicine: 11

HOSPITAL(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

What 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

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Amy Borgman, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that a notice will be posted that a physician's assistant is used, in accordance with 26 VSA, chapter 31 section 1741.

1-17-96 _____
(Date) (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 Susan
(Last) (First) (Middle) (Last)

Mailing Address Women's Choice Gynecologic Associates
(Street) (City)

23 Mansfield Ave. Burlington, VT 05401 863-9001
(State) (Zip Code) (Phone)

Office Address same as above
(Street) (City)

(State) (Zip Code) (Phone)

Vermont License #: 42-0005990 Number of years you have been practicing Medicine: 19

HOSPITAL(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:

NONE

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 Amy Borgman, P.A. only when the 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 and that in accordance with 26 VSA, Chapter 31, section 1741, the use of a physician's assistant has been posted.

1-17-96
(Date)

Susan Smith MD
(Signature of Secondary Supervising Physician)

Planned Parenthood
of Northern New England

Standing Orders for
Nurse Practitioners & Physician Assistants

The Family Planning Practitioner may:

Date Effective: January 1996

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

C. 1) 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.
2) Manage routine DMPA problems.

E. 1) 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.

I. 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)
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
Mefenamic acid (Ponstel)
Methylergonovine maleate (Methergine)
Metronidazole (Flagyl)
Naproxen sodium (Anaprox)
Nicorette gum
Nordette (for MAP only)
Norfloxacin
Nystatin
Ofloxacin

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 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.

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 12.14.95 Date

Judith Tyson MD
Collaborating Physician:

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

CENTRAL OFFICE
51 Talcott Road, #1
Williston, VT 05495

Planned Parenthood® of Northern New England

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 Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by 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:

_____ Date: 1.19.96

Medical Director:

J. Tyson MD Date: 1/24/96

Associate Medical Director:

_____ Date: 1/23/96

Susan Smith, M.D. (Secondary Supervising Physician):

_____ Date: 1.24.96

CENTRAL OFFICE
51 Talcott Road, #1
Williston, VT 05495

Planned Parenthood® of Northern New England

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.

AMY BOCCHINO

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.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

(a). WORK SITE: NUMBER ONE

Name of Practice(s): PPNNE

Street Address: 10 WASHINGTON ST

Town: BARRE VT 05641 Zip Code: _____

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

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

Do you engage in teaching at this site? ✓Yes ___No

Do you engage in research at this site? ___Yes ✓No

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

✓Salary ___Fee for service ___Capitation ___Cost based ___Other (please specify)_____

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new Medicaid patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
401	13	2	Yes	Yes	Yes	Yes

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

	Service	Hours
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
✓	General gynecological medical care	13
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(b). WORK SITE: NUMBER TWO

Name of Practice(s): PPNNE

Street Address: 41 S Main St

Town: RANDOLPH Zip Code: 05060

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

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new Medicaid patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
4011	6	1	Yes	Yes	Yes	Yes

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

	Service	Hours
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
✓	General gynecological medical care	6
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(c). WORK SITE: NUMBER THREE

Name of Practice(s): _____

Street Address: _____

Town: _____ Zip Code: _____

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

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

Do you engage in teaching at this site? ___Yes ___No

Do you engage in research at this site? ___Yes ___No

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

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

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

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

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

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

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

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

I(d). WORK SITE: NUMBER FOUR

Name of Practice(s): _____

Street Address: _____

Town: _____ Zip Code: _____

Is your practice at this site affiliated with an IPA HMO? ___Yes ___No
Is your practice at this site affiliated with a Group/Staff HMO? ___Yes ___No
Do you engage in teaching at this site? ___Yes ___No
Do you engage in research at this site? ___Yes ___No

Is your personal income from this practice site based on (check as many as apply):
___Salary ___Fee for service ___Capitation ___Cost based ___Other (please specify)_____

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

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

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

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

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

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

SPECIALTY CODES

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

101	ALLERGY & IMMUNOLOGY
102	CLINICAL & LABORATORY IMMUNOLOGY
201	ANESTHESIOLOGY
202	CRITICAL CARE MEDICINE
203	PAIN MANAGEMENT
301	COLON & RECTAL SURGERY
401	DERMATOLOGY
402	DERMATOPATHOLOGY
403	CLINICAL & LABORATORY
404	DERMATOLOGICAL IMMUNOLOGY
501	EMERGENCY MEDICINE
502	MEDICAL TOXICOLOGY
503	PEDIATRIC EMERGENCY MEDICINE
504	SPORTS MEDICINE
601	FAMILY PRACTICE
602	GERIATRIC MEDICINE
603	SPORTS MEDICINE
701	INTERNAL MEDICINE
702	ADOLESCENT MEDICINE
703	CARDIAC ELECTROPHYSIOLOGY
704	CARDIOVASCULAR DISEASE
705	CRITICAL CARE MEDICINE
706	CLINICAL & LABORATORY IMMUNOLOGY
707	ENDOCRINOLOGY DIABETES & METABOLISM
708	GASTROENTEROLOGY
709	GERIATRIC MEDICINE
710	HEMATOLOGY
711	INFECTIOUS DISEASE
712	MEDICAL ONCOLOGY
713	NEPHROLOGY
714	PULMONARY DISEASE
715	RHEUMATOLOGY
716	SPORTS MEDICINE
801	MEDICAL GENETICS
802	CLINICAL BIOCHEMICAL GENETICS
803	CLINICAL BIOCHEMICAL/MOLECULAR GENETICS
804	CLINICAL CYTOGENETICS
805	CLINICAL GENETICS (M.D.)
806	CLINICAL MOLECULAR GENETICS
901	NEUROLOGICAL SURGERY
902	CRITICAL CARE MEDICINE
1001	NUCLEAR MEDICINE
1101	OBSTETRICS & GYNECOLOGY
1102	CRITICAL CARE MEDICINE
1103	GYNECOLOGIC ONCOLOGY
1104	MATERNAL & FETAL MEDICINE
1105	REPRODUCTIVE ENDOCRINOLOGY
1201	OPHTHALMOLOGY
1301	ORTHOPAEDIC SURGERY
1302	HAND SURGERY
1401	OTOLARYNGOLOGY
1402	OTOLOGY/NEUROTOLOGY
1403	PEDIATRIC OTOLARYNGOLOGY

CODES CONTINUED
ON BACK

	PATHOLOGY (BOARD NAME - NOT A SPECIALTY)
1501	ANATOMIC & CLINICAL PATHOLOGY
1502	ANATOMIC PATHOLOGY
1503	CLINICAL PATHOLOGY
1504	BLOOD BANKING/TRANSFUSION MEDICINE
1505	CHEMICAL PATHOLOGY
1506	CYTOPATHOLOGY
1507	DERMATOPATHOLOGY
1508	FORENSIC PATHOLOGY
1509	HEMATOLOGY
1510	IMMUNOPATHOLOGY
1511	MEDICAL MICROBIOLOGY
1512	NEUROPATHOLOGY
1513	PEDIATRIC PATHOLOGY
1601	PEDIATRICS
1602	ADOLESCENT MEDICINE
1603	CLINICAL & LABORATORY IMMUNOLOGY
1604	MEDICAL TOXICOLOGY
1605	NEONATAL-PERINATAL MEDICINE
1606	PEDIATRIC CARDIOLOGY
1607	PEDIATRIC CRITICAL CARE MEDICINE
1608	PEDIATRIC EMERGENCY MEDICINE
1609	PEDIATRIC ENDOCRINOLOGY
1610	PEDIATRIC GASTROENTEROLOGY
1611	PEDIATRIC HEMATOLOGY-ONCOLOGY
1612	PEDIATRIC INFECTIOUS DISEASE
1613	PEDIATRIC NEPHROLOGY
1614	PEDIATRIC PULMONOLOGY
1615	PEDIATRIC RHEUMATOLOGY
1616	PEDIATRIC SPORTS MEDICINE
1701	PHYSICAL MEDICINE & REHABILITATION
1801	PLASTIC SURGERY
1802	HAND SURGERY
1901	PREVENTIVE MEDICINE
1902	AEROSPACE MEDICINE
1903	OCCUPATIONAL MEDICINE
1904	PUBLIC HEALTH & GENERAL PREVENTIVE
1905	MEDICAL TOXICOLOGY
1906	UNDERSEAS MEDICINE
	PSYCHIATRY & NEUROLOGY (BOARD NAME - NOT A SPECIALTY)
2001	PSYCHIATRY
2002	NEUROLOGY
2003	NEUROLOGY W/ SPECIAL QUALIFICATIONS IN CHILD NEUROLOGY
2004	ADDICTION PSYCHIATRY
2005	CHILD & ADOLESCENT PSYCHIATRY
2006	FORENSIC PSYCHIATRY
2007	GERIATRIC PSYCHIATRY
2008	CLINICAL NEUROPHYSIOLOGY
2101	RADIOLOGY
2102	DIAGNOSTIC RADIOLOGY
2103	RADIATION ONCOLOGY
2104	RADIOLOGICAL PHYSICS
2105	NUCLEAR RADIOLOGY
2106	PEDIATRIC RADIOLOGY
2107	VASCULAR & INTERVENTIONAL RADIOLOGY
2201	SURGERY
2202	SURGERY OF THE HAND
2203	PEDIATRIC SURGERY
2204	SURGICAL CRITICAL CARE
2205	GENERAL VASCULAR SURGERY
2301	THORACIC SURGERY
2401	UROLOGY

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
4005	ALLERGY
4006	CARDIOVASCULAR SURGERY
4007	CLINICAL PHARMACOLOGY
4008	DIABETES
4009	FACIAL PLASTIC SURGERY
4010	GENERAL PRACTICE
4011	GYNECOLOGY
4012	HEAD & NECK SURGERY
4013	HEPATOLOGY
4014	HOMEOPATHIC MEDICINE
4015	IMMUNOLOGY
4016	LEGAL MEDICINE
4017	MUSCULOSKELETAL ONCOLOGY
4018	NEURORADIOLOGY
4019	NUTRITION
4020	OBSTETRICS
4021	ORAL & MAXILLOFACIAL SURGERY
4022	ORTHOPEDIC SURGERY OF THE SPINE
4023	ORTHOPEDIC TRAUMA
4024	PAIN MEDICINE
4025	PEDIATRIC ALLERGY
4026	PEDIATRIC OPHTHALMOLOGY
4027	PEDIATRIC ORTHOPEDICS
4028	PEDIATRIC SURGERY (NEUROLOGY)
4029	PEDIATRIC UROLOGY
4030	PSYCHOANALYSIS
4031	RADIOISOTOPIC PATHOLOGY
4032	SPORTS MEDICINE (ORTHOPEDIC SURGERY)
4033	TRAUMATIC SURGERY
9999	OTHER - PLEASE SPECIFY IN ALL PLACES WHERE THIS CODE IS USED

CODES CONTINUED
ON FRONT

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

(a). WORK SITE: NUMBER ONE

Name of Practice(s): PPNNE
Street Address: 23 MANSFIELD AVE
Town: BURLINGTON VT. Zip Code: 05401

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

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new Medicaid patients in this specialty? YES or NO	Will you accept new Medicare patients in this specialty? YES or NO
4011	2	12	Yes	Yes	Yes	Yes

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

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

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.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

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

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 Pediatrics	126 Cherry St., Burlington	NUMBER ONE
City Hospital	Pine St., Burlington	NUMBER TWO
Mountain Pediatrics	Route 116, Hinesburg	NUMBER THREE
Lakeview Pediatrics	Route 7, Vergennes	NUMBER FOUR

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.

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

(a). WORK SITE: NUMBER ONE

Name of Practice(s): PPNE

Street Address: Main ST

Town: Hyde Park VT Zip Code: 05655

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

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

Do you engage in teaching at this site? ___Yes ✓No

Do you engage in research at this site? ___Yes ✓No

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

✓Salary ___Fee for service ___Capitation ___Cost based ___Other (please specify)_____

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

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

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

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

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

	Service	Hours
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
✓	General gynecological medical care	6
	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.

****

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 S. BORGMAN 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: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: 90 WASHINGTON ST

City, State, Zip Code: Barre VT 05036

6. Daytime Telephone Number: Area Code: (802) 476-6696

7. Date of Birth: Month: [redacted] Day [redacted] Year [redacted]

8. Place of Birth: [redacted] 9. Sex: ____ Male ____ Female

10. Certification Examination Taken - Check:

X NCCPA

_____ State Examination-Identify State: _____

_____ Other Examination Specify: _____

11. Basis for Vermont Certification: _____ Apprenticeship Trained

X University 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.A.~~ B.S. A.B. Other: _____ Year of Graduation: 1982

Degree Granting Institution: GEORGE WASHINGTON UNIVERSITY

Location: WASH. DC

First Institution (If transfer): _____ Location: _____

P.A. Diploma or Certificate: _____ Other: _____ Year of Graduation: _____

School: _____ Location: _____

13. Do you have hospital privileges **in Vermont**? _____ Yes X No

Name(s) and Location(s) of Hospital(s): _____

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

15. Other states where you now hold an active certification or license to practice: none

16. States where you previously were certified or licensed to practice: VIRGINIA

17. Specialty: GYN DEA Number: none

18. Name and office address of current employer:

Name	**Address**
PPNNE	23 MANSFIELD AVE

19. Please review the attached list of current Primary and Secondary Supervising Physicians. Is the information correct? ____ Yes ____ No If no, contact the Board. If no list is attached, please fill out the information below:

Name, specialty and office address of Supervising Physician(s):

Name	**Specialty**	**Address**
Judith Tyson MD	OB/GYN	PPNNE 51 TALCOTT RD, WILLISTON, VT 05495
Cheryl Gibson MD	OB/GYN	Woman's Choice 23 MANSFIELD AVE BURL. VT 05401

20. Name, specialty and office address of the Secondary Supervising Physician(s):

Name	**Specialty**	**Address**
SUSAN SMITH MD	OB/GYN	Women's Choice 23 Mansfield Ave, BURL VT 05401

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 ____ (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 II - "Yes" answers to Questions 1 - 24 requires an explanation on the enclosed Form A. During the past two years:

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

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.

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

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

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

21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, 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," pl[redacted]

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

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)

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

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

or

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

Applicant's Statement Regarding Taxes

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

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

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

or

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

Applicant's Statement Regarding Unemployment Compensation Contributions

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

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

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 1.5.98

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

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

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

   (b) How many hours per week do you spend on administration, teaching and research? 8 hours

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

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

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
   (Month/Year) 9/82

4. 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? ___Yes ✓ No

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(a). WORK SITE: <u>NUMBER ONE</u>

Town: Barre VT County: WASHINGTON

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

Check the <u>ONE</u> practice setting from the selections below that most accurately reflects your practice at this site:

<u>PRACTICE SETTINGS</u>

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

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

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.

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	1101	06 / GYN	12
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

Are you working with physician's assistants and/or nurse practitioners at this site? ✓Yes ___No
If yes, enter the number of: Physician's Assistants 1 (mid) Nurse Practitioners 2 NP 1 CNM

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(b). WORK SITE: NUMBER TWO

Town: RANDOLPH County: ORANGE

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

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

PRACTICE SETTINGS

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

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

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

	Specialty Code	Specialty Name	Hours Per Week
Primary Specialty at this Site	1101	06/ (GYN)	8
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

Are you working with physician's assistants and/or nurse practitioners at this site? (Yes) ___No

If yes, enter the number of: Physician's Assistants 1-(me) Nurse Practitioners ____

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(c). WORK SITE: <u>NUMBER THREE</u>

Town: _____ County: _____

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

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

<u>PRACTICE SETTINGS</u>

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

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

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

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

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

Will you accept new patients at this site? ___Yes ___No

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

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

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

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

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(c). WORK SITE: NUMBER FOUR

Town: _____ County: _____

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

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

PRACTICE SETTINGS

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

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

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

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

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

Will you accept new patients at this site? ___Yes ___No

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

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

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

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

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

CENTRAL OFFICE
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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

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

C. 1) 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.
2) Manage routine DMPA problems.

E. 1) 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.

I. 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)
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

PNP 1.5.98

Signature Date

Collaborating Physician:
Judith Tyson, MD, Medical Director, PPNNE
Cheryl Gibson, MD, Assoc. Med. Dir.

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

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

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by 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 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:

_____ Date: 1/19/98

Medical Director:

_____ MD Date: 12/29/97

Associate Medical Director:

_____ MD Date: 12/30/97

Susan Smith, M.D. (Secondary Supervising Physician):

_____ Date: 1/6/98

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

72556-97

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

TOTAL FORMS & SYSTEMS 172686

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
[redacted]

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

AMY S. BORGMAN

has met the requirements for certification and is entitled to use the designations
PHYSICIAN ASSISTANT-CERTIFIED *and* **PA-C**

Certificate No.: 830420
Expiration Date: 06/01/99

Executive Vice President

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

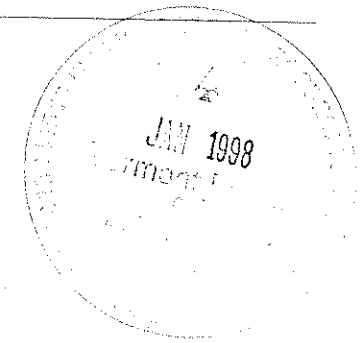
72556A-97

CENTRAL OFFICE
51 Talcott Road, #1
Williston, VT 05495

Planned Parenthood® of Northern New England

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.

Amy Borgman
[redacted]

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

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 have hereunto set my hand and affixed the official seal of

Vermont Board of Medical Practice
(Regulating Board or Court)

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

this 26th day of January, A.D., 19 96

Debbie Morehouse
Administrative Assistant

1/26/96 License sent from renewal

Renewal

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 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

Janice E Fifield

Administrative Assistant

Amy Bozgman - 30098

PA CHECK LIST (RENEWAL) - 2000-2002

P	1.	Fee 75.00
Y	2.	Application pages complete
Y	3.	Child/Tax/Unemployment
N/A	4.	Form A when applicable
Y	5.	NCCPA or CME proof
Y	6.	Signed (by both) Scope of Practice
Y	7.	Supervisor Statement

Survey — (Yes) X — NO —

Pd
75

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.**

JAN 2000
Vermont Board of Medical Practice

055-0030098

Amy S. Borgman PA-C
Planned Parenthood of Northern N.E.
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 S BORGMAN 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: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: 90 WASHINGTON St

City, State, Zip Code: Barre VT 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) 476-6696

7. Date of Birth: Month: [redacted] Day [redacted] Year [redacted]

8. Place of Birth: [redacted] 9. Sex: ___ Male ___ (Female)

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 - Circle: (B.A.) B.S. A.B. Other: _____ Year of Graduation: 1973

Degree Granting Institution: SUNY @ Albany

Location: @ Albany NY

First Institution (If transfer): _____ Location: _____

P.A. Diploma or Certificate: BS Other: _____ Year of Graduation: 1982

School: George Washington University Location: WASH DC

13. Do you have hospital privileges in Vermont? ____ Yes ____ (No)

Name(s) and Location(s) of Hospital(s): _____

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

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

16. States where you previously were certified or licensed to practice: VIRGINIA ~1986

17. Specialty: GYN DEA Number: none

18. Name and office address of current employer:

Name	Address
PPNNE	

19. Please list (or use additional sheet if necessary) your current Primary and Secondary Supervising Physicians:

Name, specialty and office address of Supervising Physician(s):

Name	Specialty	Address
Judy Tyson	OB/GYN	PPNNE 183 TAFT RD. Williston, VT. 05495
		" 89 So. Main St. West Lebanon, NH. 03784
Cheryl Gibson	OB/GYN	PPNNE 23 Mansfield Ave. Burl, VT. 05401

20. Name, specialty and office address of the Secondary Supervising Physician(s):

Name	Specialty	Address
Susan Smith	OB/GYN	PPNNE 23 Mansfield Ave. Burl, VT. 05401

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 ___(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? ____Yes ____(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 healing art in lieu of disciplinary action? ____Yes ____(No)

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

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

6. Have you been denied the privilege of taking an examination before any State Medical Examining Board? ____Yes ____(No)

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 institution denied, reduced, suspended or revoked; resigned from a medical staff in lieu of disciplinary action; or resigned from a medical staff after a complaint or peer review action has been initiated against you? ____Yes ____(No)

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? ____Yes ____(No)

12. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? ____Yes ____(No)

13. Have you been turned down for coverage by a malpractice insurance carrier? ____Yes ____(No)

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

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

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
2000-2002 PHYSICIAN'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:

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 P[redacted]nd 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[redacted]and safety? If "yes," please explain.

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

20. Are the limitations or impairments caused by your medical condition reduced or ameliorated becau[redacted] 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, exhibitioni[redacted]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," p[redacted]

24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, parar[redacted]ic 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. § 795)

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

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

or

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

Applicant's Statement Regarding Taxes

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

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

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

or

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

Applicant's Statement Regarding Unemployment Compensation Contributions

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

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

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

or

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

Social Security #_____* Date of Birth _____

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

STATEMENT OF APPLICANT

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

Signature of Applicant_____ Date 12.14.99

Amy Bauman

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

C. 1) 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.
2) Manage routine DMPA problems.

E. 1) 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.

I. 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)
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)
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 Fumarate
Ferrous Gluconate
Ferrous Sulfate
Fluconazole
Ibuprofen (Motrin, Nuprin, Advil)
Ipecac syrup
Ketoconazole
Ketorolac
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
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

12-27-99

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 Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by 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.

   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 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:

_____ Date: 12-27-99

A Bagnall

Medical Director:

_____ Date: 1/13/2000

Associate Medical Director:

_____ Date: 1/16/2000

Susan Smith, M.D. (Secondary Supervising Physician):

_____ Date: 1/19/00

Planned Parenthood® of Northern New England

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

Planned Parenthood®
of Northern New England

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

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

PRESIDENT

VICE PRESIDENT

IMMEDIATE PAST PRESIDENT

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS
NCCPA

SECRETARY

TREASURER

MEMBER AT LARGE

EXECUTIVE DIRECTOR

Certificate Number: 1011373
Issue Date: November 19, 1999
Expiration Date: June 1, 2001

This certificate is the property of the NCCPA and must be returned to the NCCPA upon request.

PLANNED PARENTHOOD
of Northern New England

FROM: Bev
183 Talcott Road, Suite 101
Williston, Vermont 05495-2075

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

DATE: 1/26/00

TO: Janice Fifield

PHONE #:

FAX #: (802) 828-5450

Number of pages (including cover page) 2

RE: Amy Borgman's VCC Certification

Thank you Janice !

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, 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 98

Janice E Fifield
Administrative Assistant

Processed 1-22-02
05.00 AP
10.00 LP

PA CHECK SHEET
2002-2004 RENEWAL

Name Amy Borgman
Cerification # 055.05030098
Date Received 1-22-02

✓	Fee $75.00
✓	Application Pages Complete
N/A	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

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. Borgman

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: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: 90 Washington St.

City, State, Zip Code: Barre VT 05641

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) 476-6696

7. Date of Birth: Month: [redacted] Day [redacted] Year [redacted]

8. Place of Birth: [redacted]

9. Certification Examination Taken - Check:

___✓___ NCCPA

_____ State Examination-Identity State: _____

_____ 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

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

13. Other states where you now hold an active certification or license to practice: Ø

14. States where you previously were certified or licensed to practice: VIRGINIA

15. Specialty: GYN DEA Number: _____

16. Name and office address of current **EMPLOYER**:

Name: Planned Parenthood of Northern New England Address: 183 TALCOTT RD #101 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: Cheryl Gibson Address: 23 Mansfield ave. Burl, VT. 05482

Secondary Supervising Physician(s):

Name: Susan Smith Address: 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 ✓ No

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

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:

1. Have you applied for and been denied a certification/license to practice as a PA or any healing art? ____ Yes ✓ 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 healing art in lieu of disciplinary action? ____ Yes ✓ No

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

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

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

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 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? ✓ Yes ____ No

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

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

12. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? ____ Yes ✓ No

13. Have you been turned down for coverage by a malpractice insurance carrier? ____ Yes ✓ No

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

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

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

2002-2004 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

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.

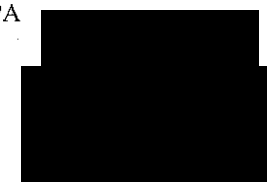
20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If "yes", please explain.

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.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 1-3-02

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.

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS

NCCPA

Elaine E. Grant

Elaine E. Grant, MPH, PA-C, President

I. Kathryn Hill, MEd, Executive Director

G E Winchester M.D.

G.E. Winchester, MD, Secretary

Certificate Number: 1011373
Issue Date: June 6, 2001
Expiration Date: December 31, 2003

Planned Parenthood
of Northern New England

Standing Orders for
Nurse Practitioners & 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; 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.
3) Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.

C.
1) 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.
2) Manage routine DMPA problems.

E.
1) 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.

I. 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, titers and sonograms.

M. 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.

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.
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

Anny S Bergman pnp 5/15/01

Signature Date Collaborating Physician

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

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

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

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

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

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

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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.

Amy S Baragwanath 1.3.02

Physician's Assistant Date

1/17/02

Medical Director Date

Cheryl Gibson

Susan Smith MD 1/17/02

Susan Smith, M.D. Date

Secondary Supervising Physician

Planned Parenthood®
of Northern New England

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

Planned Parenthood® of Northern New England

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 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.

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A. (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 (802) 863-6326
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care - Fanny Allen	Burl, VT.	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:
Coverage by two other P.P M.D's: Susan Smith and Galyn Thomas

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 Amy Bergman, P.A. while under my supervision. I further certify that the protocol outlining 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's 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's assistants.

1/17/02 (Date)

X (Signature of Supervising Physician)

Co-signature of PA: Amy Bergman

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number N/A

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith (Last) Susan (First) Fay (Middle)

Mailing Address Planned Parenthood (Office Name)
23 mansfield ave. (Street)
Burlington, VT. 05401 (802) 863-6326
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care - Fanny Allen	Burl., VT	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - P.P Barre, VT Joanne Gutt P.P Derry, VT. Cate Nicholas P.P Burl, VT.
August Burns - P.P Nycke PK. VT Johanna Hauser P.P Burl, VT Barbara Nolfi P.P Burl, VT.
Sue Burton - P.P Burl, VT. Katra Kindar P.P Burl, VT. Judy Wechsler P.P Burl, VT.
Janet Young P.P Burl, VT.

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 Amy Borgman, 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 and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician's assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician's assistants.

11/7/02 (Date)

(Signature of Secondary Supervising Physician)

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

RECEIVED
JAN 28 2004
VERMONT BOARD OF MEDICAL PRACTICE

1. Name: Amy S. Borgman
2. Gender: ☐ Male ☒ Female
3. Vermont Certification Number: 055-0030098
4. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere: _____
5. Home Address: [redacted]
   City, State, Zip Code: [redacted]
6. Work Address: [redacted]
   PPMNE
   90 WASHINGTON St
   BARRE VT 05641

Please check your preferred mailing address: ☐ Home ☑ Work
(This address will be public and listed on the Board's website)

7. Email Address [redacted]
8. Daytime Telephone Number: Area Code: (802) 476-6696
9. Date of Birth (Month/Day/Year): [redacted]
10. Place of Birth: [redacted]

11. Certification Examination Taken – (Check box and enter date of examination):

- ☐ (3/16/01) NCCAA Cert. issued 6/6/01
- ☐ (__/__/__) State Examination-Identity by state:_____
- ☐ (__/__/__) Other Examination specify: _____

12. Basis for Vermont Certification – (Check box):

- ☐ Apprenticeship Trained
- ☑ University Trained

13. Do you have hospital privileges in Vermont? ☐ Yes ☑ No

Hospital Name(s) and Location(s): _____

14. In what year did you start working as a physician assistant in Vermont? 1986

15. Did you practice in Vermont during the past 12 months? ☑ Yes ☐ No

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

16. Other states where you now hold an active certification or license to practice: Ø

17. States where you previously were certified or licensed to practice: VIRGINIA

18. Specialty: GYN DEA Number: MB0763234

19. Name and office address of current **EMPLOYER**:

Name	Address
Planned Parenthood	90 Washington St. Barre, VT. 05641

20. Please indicate the total number and list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your **PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).**

Total number 3

Primary Supervising Physician(s):

Name: Cheryl A. Gibson
Address:
23 Mansfield Avenue
Burlington, VT 5401

Name	Address
_____	_____

Secondary Supervising Physician(s):

Name Susan Smith — Address 23 Mansfield Ave. Burl, VT. 05401

Kym Bayman

21. 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

22. 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.

23. **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 logging form must be completed.

24. 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 25 - 39 require an explanation on 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.

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

Certification and Practice Questions

25. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art? ☐ Yes ☑ No

26. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art? ☐ Yes ☑ No

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

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

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

30. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation? ☐ Yes ☑ No

31. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion? ☐ 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? [redacted]

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

MEDICAL QUESTIONS

Please answer "**Yes**" or "**No**" to the questions below. Definitions are provided 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:

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**" – 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

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?

[redacted]

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

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?

[redacted]

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

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

[redacted]

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

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)

B. Other Restrictions

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 copies of papers fully documenting these matters.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

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

A. Judgments

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

☐ Judgement ☐ Arbitration

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

☐ Judgement ☐ Arbitration

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

B. Settlements

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

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician's Assistant? 10/82

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

A. Appointments

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

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

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

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

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

Note: Answering #51 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)

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

Note: Answering #52 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)

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

What is the location of your primary practice setting?

90 WASHINGTON St Barre VT 05641

Town/City, State

51. 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:

_____

_____

_____

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

A. Medicaid participation
Do you participate in the Medicaid program? ☑ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☑ Yes ☐ No

Part V

Are you currently active in clinical practice in Vermont? ☑ Yes ☐ No

If you do not provide patient care in Vermont, skip the rest of Part V and go to Part VI.

For the practice location(s) in Vermont related to this certificate, please answer the questions below.

Please select the specialty codes from the list provided (link), and enter the average hours per week you spend providing DIRECT PATIENT CARE. Include both AMBULATORY care and HOSPITAL care of patients who originate from this site. Please exclude on-call hours.

Enter the Vermont town name for this location: Barre VT

Select the ONE practice setting that best describes this practice:
(If you provide hospital care to patients who originate from your office or clinic, choose only the setting from which they originate.)

☑ Community-Based practice (including associated hospital care - solo or group office, Community Health Center, etc.)
☐ Hospital-based practice (Inpatient, Emergency Room, etc)
☐ School or College Health Center
☐ Business or Work Site
☐ Extended Care / Nursing Home
☐ Other:_____

I work as a locum tenens here ☐ Yes ☑ No

If this is an office-based practice, please answer the following:

I currently have patients here covered by Medicaid ☑ Yes ☐ No
I currently have patients here covered by Medicare ☑ Yes ☐ No
I will accept new patients here ☑ Yes ☐ No
I will accept new Medicaid patients here ☑ Yes ☐ No
I will accept new Medicare patients here ☑ Yes ☐ No

Enter the number of weeks you spend providing direct patient care here in a year:
(48 weeks is considered to be "full time") 50 [2 digits]

Enter your specialty and the number of hours you spend providing direct patient care here under that specialty in an average work week:

First Specialty: 1101 [4 digits] (see attached list or link) 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 AT THIS SITE in the next 12 months? ☐Yes ☒No

If you work at another location or setting UNDER THE SAME CERTIFICATE please answer the questions below. If you work only at one site under this certificate please stop here, leave Part V blank, and skip to Part VI. (If you work at another site under a different certificate, please describe your work at that site in the renewal form for that other certificate, not here.)

Enter the Vermont town name for the second location: RANDOLPH

Select the ONE practice setting that best describes this practice:
(If you provide hospital care to patients who originate from your office or clinic, choose only the setting from which they originate.)

- ☒ Community-Based practice (including associated hospital care - solo or group office, Community Health Center, etc.)
- ☐ Hospital-based practice (Inpatient, Emergency Room, etc)
- ☐ School or College Health Center
- ☐ Business or Work Site
- ☐ Extended Care / Nursing Home
- ☐ Other: _____

I work as a locum tenens here ☐Yes ☒No

If this is an office-based practice, please answer the following:

I currently have patients here covered by Medicaid	☒Yes ☐No
I currently have patients here covered by Medicare	☒Yes ☐No
I will accept new patients here	☒Yes ☐No
I will accept new Medicaid patients here	☒Yes ☐No
I will accept new Medicare patients here	☒Yes ☐No

Enter the number of weeks you spend providing direct patient care here in a year:
(48 weeks is considered to be "full time") 50 [2 digits]

Enter your specialty and the number of hours you spend providing direct patient care here under that specialty in an average work week:

First Specialty: 1101 [4 digits] (see attached list or link) Hours per week: 6 [2 digits]

Second Specialty: _____ [4 digits] (see attached list or link) Hours per week: ____ [2 digits]

Do you plan to retire or reduce your patient care hours AT THIS SITE in the next 12 months? ☐Yes ☒No

If you work at more than two locations UNDER THE SAME CERTIFICATE please describe the additional site(s) briefly, e.g., "same specialty and hours in additional towns: X and Y":

same specialty and

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: 12/16/03

Applicant's Signature

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

487-34-1720

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 12.16.03

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 (City/State) (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
F.A.H.C	Burlington, VT. 05401	OB/GYN.

What arrangements have you made for supervision when you are not available or out of town:
24/7 on call Service
Two Back-up Secondary Supervising Physicians.

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 Amy Borgman, P.A. while under my supervision. I further certify that the protocol outlining 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's 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's assistants.

1/15/04 (Date)

X (Signature of Supervising Physician)

Co-signature of PA: Amy S Borgman

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

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 Boyman (Last) Kym (First) M. (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield AVE. (Street)
Burlington, VT. 05401 (City/State) (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0010597

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
F.A.H.C	Burlington, VT.	OB/GYN.

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - P.P BARRE Johanna Hauser - P.P Burlington Barb Nafi - P.P Burl.
August Burns - P.P Hyde Park Katra Kindar - P.P Burlington Janet Yang - P.P Burl.
Sue Burton - P.P Burlington Cate Nicholas - P.P Burlington Anne Hildreth - Springfield

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 Amy Borgman, 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.

I further certify that I have read the statutes and Board rules governing physician's assistants.

1/22/04 (Date)

X (Signature of Secondary Supervising Physician)

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 (Last) Susan (First) — (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burl, VT. 05401 (City/State) (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
F.A.H.C	Burlington, VT.	OB/GYN.

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - P.P BARRE Johanna Hauser - P.P Burlington Barb Nolfi - PP Burl.
August Burns - P.P Hyde Park Katra Kindar - P.P Burlington Janet Young - P.P Burl.
Sue Burton - P.P Burlington Cate Nicholas - P.P Burlington Anne Hildreth P.P Springfield

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 Amy Borgman, 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.

I further certify that I have read the statutes and Board rules governing physician's assistants.

1/22/04 (Date)

Susan Smith (Signature of Secondary Supervising Physician)

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

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

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

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

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

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

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

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

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

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

Amy Bergman 1.20.04
Physician's Assistant Date
Amy Bergman

Cheryl Gibson MD 1/15/04
Cheryl Gibson Date
Primary Supervising Physician

Planned Parenthood® of Northern New England

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 on-going basis. These are incorporated into PPNNE'S protocol.

Planned Parenthood
of Northern New England

Standing Orders for
Nurse Practitioners & Physician Assistants

e 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; 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.
3) Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.

C. 1) 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.
2) Manage routine DMPA problems.

E. 1) 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.

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.

e 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.

ree to practice under the above standing orders

Amy S Borgman
l Name

nature 5-9-03 Date

Collaborating Physician: Cheryl Gibson, MD, Medical Director

NE 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.

Sincerely,

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.

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS
NCCPA

Gary E. Winchester, MD, Chairman of the Board

Janet J. Lathrop, President

Dorothy D. Pearson, PA-C, Secretary

Certificate Number: 1011373
Issue Date: November 3, 2003
Expiration Date: December 31, 2005

PD
75.00
+5.00

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

PART I

Certificate # 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. Home Address:

[redacted]

4. Work Address: 90 WASHINGTON ST

City, State, Zip Code: BARRE VT 05641

Please check your preferred mailing address: ☐ Home ☑ Work
(This address will be public and listed on the Board's website)

5. Email Address [redacted]

6. Daytime Telephone Number: Area Code: (802) 476.6696

7. Date of Birth: Month: [redacted]

JAN 5 2006

8. Place of Birth: [redacted]

9. Certification Examination Taken – (Check box and enter date of examination):

☐ (3 / 16 / 2001) 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):

12. In what year did you start working as a physician assistant in Vermont? _____

13. Did you practice in Vermont during the past 12 months? ☐ Yes ☐ No

14. Other states where you now hold an active certification or license to practice:

15. States where you previously were certified or licensed to practice:

16. Specialty: _____ DEA Number: _____

17. Name and office address of current EMPLOYER:

Name 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).

Primary Supervising Physician(s):

Name Address

Secondary Supervising Physician(s):

Name Address

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.

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 ☒ no

24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes ☒ no

25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?
□ yes ☒ no

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

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

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

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

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

31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
□ yes ☒ no

32. 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? [redacted]

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

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?

[redacted]

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

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?

[redacted]

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

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

[redacted]

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

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://healthyvermonters.com/bmp/mbsearchform.shtml.

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.

38. 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)

39. 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 "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 complete copies of documentation 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 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)

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.**

(Date) (Hospital) (State)

(Nature of Action) (Action) ☐ In lieu
☐ In settlement
(Reason for Action)

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

A. Judgments ☒ Check here if none

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

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☒ Check here if none (BP)

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) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician Assistant? June 1984

45. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☐ Check here if none

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

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician Assistant? _____

45. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

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

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

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

Note: Answering #49 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 #50 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)

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

What is the location of your primary practice setting?

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:

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

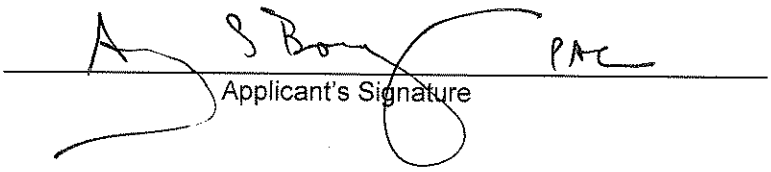
A. Medicaid participation
Do you participate in the Medicaid program? ☐ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☐ Yes ☐ No

Part V

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: 11.19.05



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 Amy Bergman #055-0030098

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 11.19.05

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.

Certificate Number: 1011373

Effective On: November 7, 2005

Dorothy D. Pearson, PA-C, Chairman of the Board

Janet J. Lathrop

Amy Borgman # 055-0030098

PAGE 1

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
PRACTINSERVICES - PRESENTATIONS/PE	JUNE 9 2005	5	ACCME	UNIV. OF VT, BURL
BIPOLAR DISORDER: MGT STRATEGIES	MAY 5 2005	3	AMA PRA	MONOGRAPH
RURAL HEALTH SYMPOSIUM	MAY 4 2005	4	ACCME	WHITEFIELD NH
UPDATE IN WOMENS HEALTH	MAY 2 2005	5.5	ACCME	DHMC LEBANON NH
JAAPA-SELF ASSESSMENT QUIZ	MAY 4, 2005	1	AAPA	JAAPA JOURNAL MARCH 2005 VOL 18
JAAPA-SELF ASSESSMENT QUIZ	MAY 4, 2005	1	AAPA	JAAPA JOURNAL OCT. 2004 VOL 17

19.5

CATEGORY II

Program Title	Date	CME Hours	Sponsor	Location
OVERACTIVE BLADDER-TX STRATEGIES	APRIL 15, 2005	2	AMA PRA	MONOGRAPH
BREATHING EASIER-COPD MGT	APRIL 13, 2005	3	AMA PRA	MONOGRAPH
NEW ADVANCES IN COPD MGT	FEB 24, 2005	1	AMA PRA	MONOGRAPH
PRAC. INSERVICE	APRIL 1, 2005	5.75	AMA PRA	CONCORD NH
JAAPA-SELF ASSESSMENT QUIZ	MARCH 29, 2005	1	AAPA	JAAPA JOURNAL DEC. 2004 VOL. 17
JAAPA-SELF ASSESSMENT QUIZ	FEB. 18, 2005	1	AAPA	JAAPA JOURNAL SEPT. 2004 VOL 17

13.75

Total Category I Hours: 33.25 + Total Category II Hours: _____ = **Total Hours:** 33.25

Your Signature: _____

PAGE 2

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

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CATEGORY I

Program Title	Date	CME Hours	Sponsor	Location
UPDATE IN REPRO-DUCTIVE HEALTH	OCT. 22, 2004	6	AMA PRA	BOSCAWEN NH
CLINICIAN'S OVER-VIEW OF TOBACCO TX	OCT. 6 2004	1.5	AMA PRA	MONOGRAPH
PRAC. IN-SERVICE: CASE HX. REVIEWS	JUNE 10 2004	6	AMA PRA	RANDOLPH, VT
RURAL HEALTH SYMPOSIUM	MAY 5 2004	6	AMA PRA	BARNET VT
AB. RESISTANT RESP. TRACT BACTERIA	April 27, 2004	1	AAPA	MONOGRAPH
PRAC IN-SERVICE	MARCH 26, 2004	6	AMA PRA	CONCORD, NH

26.5

CATEGORY II

Program Title	Date	CME Hours	Sponsor	Location
EXTENDED CYCLE CONTRACEPTION	MARCH 18, 2004	2	AMA PRA	MONOGRAPH
CURRENT STRATEGIES FOR HIP FX. PREVENTION	MARCH 10, 2004	1	AAPA	TELECONFERENCE
HSV MGT: COMP. APPROACH TO TX.	MARCH 2004	1.5	AAPA	MONOGRAPH
FOCUS ON OVER-ACTIVE BLADDER	Feb. 3 2004	1.5	AMA PRA	MONOGRAPH
PELVIC HEALTH & the Bladder	Feb. 16 2003	1	AMA PRA	TELECONFERENCE
COLPOSCOPY IN-SVC	NOV. 21, 2003	5.5	AMA PRA	HANOVER NH

12.5

Total Category I Hours: 39 + Total Category II Hours: _____ = **Total Hours:** 39

Your Signature: _____

PAGE 3

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
WOMEN'S HEALTH: Focus on Sexuality	OCT. 17 2003	6	AMA PRA	CONCORD NH
ADVANCES IN CONTRACEPTION	OCT. 2003	2	AAPA	MONOGRAPH
NEW PARADIGMS FOR Tx. of ACID-related disorders	OCT. 2003	2	AAPA	MONOGRAPH
clearing the Air - Mgt of Asthma/Rhinitis	OCT. 2003	2	AAPA	MONOGRAPH
DEMENTIAS - MGT. IN TX.	MAY 14, 2003	2	AMA PRA	MONOGRAPH

CATEGORY II

Program Title	Date	CME Hours	Sponsor	Location
PRECEPT NURSING NP, UVM STUDENT 2.	JAN - APRIL 2004	20	PPNNE	BARRE VT

Total Category I Hours: 14 + Total Category II Hours: 20 = **Total Hours:** 34 pg 3

Your Signature: _____

39 pg 2

33.25 pg 1

106.25

Amy Bergman # 055-0030098

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A. (Middle)

Mailing Address Planned Parenthood (Office Name)

193 Talcott RD (Street)

Williston, VT. (City/State) 05495 (Zip Code) (802) (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burlington	OB/GYN

What arrangements have you made for supervision when you are not available or out of town:

Coverage by another physician

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 Amy Bergman, P.A. while under my supervision. I further certify that the protocol outlining 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.

12/15/05 (Date)

X (Signature of Supervising Physician)

Co-signature of PA:

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

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

Name in full Smith (Last) Susan (First) F. (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott RD. (Street)

Williston, VT (City/State) 05495 (Zip Code) (802) 878-7230 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burlington	OB/Gyn

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - Barre, VT. Catherine Nicholas - Burlington, VT.
August Bums - Hyde, VT Katra Kinnar - Burl, VT
Sofanna Hauser - Williston, VT. Janet Young - Burl, VT.
Anne Hildreth - Barre, VT.

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible forall medical activities of Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice,attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

12/18/05 (Date)

X (Signature of Secondary Supervising Physician)

Amy Borgman # 055-0030098

Planned Parenthood® of Northern New England

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

Amy Borgman # 055-0030098

Planned Parenthood
of Northern New England

Standing Orders for
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; 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.
3) Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.

C. 1) 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.
2) Manage routine DMPA problems.

E. 1) 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, cervica mucus and calendar.

I. Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory an 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 protoc

L. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms

M. Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well chil 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 PPNN 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 parent 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

Amy S Borgman PA
Print Name

Signature 4-19-05
Date

Collaborating Physician: Cheryl Gibson, MD, Medical Dir

PPNNE Form 10HR 9/21/04es

Amy Bergman # 055-0030098

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

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

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

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

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

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

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

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

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

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.

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

PART I

Certificate #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. Work Address:

PPNNE
183 Talcott Road
WILLISTON VT 05495

4. Home Address: [redacted]

City, State, Zip Code: [redacted]

Please check your preferred mailing address: ☐ Home ☒ Work
(This address will be public and listed on the Board's website)

5. Email Address [redacted]

6. Daytime Telephone Number: Area Code:

(802) 476-6696

RECEIVED
OCT 26 2007
Vermont Board of Medical Practice

7. Date of Birth: [redacted]

8. Place of Birth: [redacted]

9. Certification Examination Taken (Check box and enter date of examination):

☐ (10/15/07) 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):

12. In what year did you start working as a physician assistant in Vermont? 1986

13. Did you practice in Vermont during the past 12 months? ☑ Yes ☐ No

14. Other states where you now hold an active certification or license to practice:
—

15. States where you previously were certified or licensed to practice:
Virginia, DC

16. Specialty: GYN DEA Number: MB 0763234

17. Name and office address of current EMPLOYER:

Name	Address
PPNNE	183 TALCOTT RD WILLISTON 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	Address
Cheryl Gibson	23 MANSFIELD AVE BURLINGTON VT 05401

Secondary Supervising Physician(s):

Name	Address
SUSAN SMITH	23 MANSFIELD AVE BURLINGTON VT 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.

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 ☒ no

24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes ☒ no

25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?
□ yes ☒ no

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

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

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

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

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

31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
□ yes ☒ no

32. 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? [redacted]

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

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? [redacted]

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

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? [redacted]

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

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

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

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.

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

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

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide complete copies of documentation 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)] X Check here if none

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

(Date) (Final Disposition - Summary)

(Date) (Final Disposition - Summary)

(Date) (Final Disposition - Summary)

41. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]
☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide complete copies of documentation for each matter.**

Ø

(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)

42. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☒ Check here if none

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 complete copies of documentation for each matter.**

Ø

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

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

B. Other Restrictions ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

Ø

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

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

A. Judgments ☒ Check here if none

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

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

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☒ Check here if none

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

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician Assistant? 1982

45. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #45 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

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

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

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)

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

What is the location of your primary practice setting?

BARRE VT

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 program for locating translation services

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

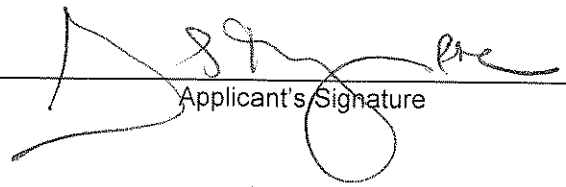
A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V

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.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due 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 of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 11.9.07

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott Road (Street)

Williston, VT. (City/State) 05495 (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burl, VT.	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:
24/7 oncall service, backed up by two MD's.

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 Amy Bergman, P.A. while under my supervision. I further certify that the protocol outlining 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.

12/17/09 (Date)

X _____ (Signature of Supervising Physician)

Co-signature of PA: _____

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763434

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 (Last) Susan (First) — (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott RD. (Street)

Williston, VT. 05495 (City/State) (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burl, VT.	OB/Gyn

List all physician's assistants names and addresses you currently supervise:

Amy Borsman - 90 Washington St. Barre, VT.
August Burns - 213 East Main St. Hyde Park, VT.
Johanna Hauser - 183 Talcott RD. Williston, VT.

over →

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible forall medical activities of Amy Borsman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice,attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

12/19/07 (Date)

X Susan Smith (Signature of Secondary Supervising Physician)

Planned Parenthood®
of Northern New England

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

Physician Assistant-Certified

designation.

Certificate Number: 1011373

Effective On: November 7, 2005

Dorothy D. Pearson, PA-C, Chairman of the Board

Grant C. Arthur

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

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

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by 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, 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 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.

PLANNED PARENTHOOD
Northern New England

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

The Family Planning Practitioner may:

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

B. 1) Order and dispense hormonal contraceptives and HT/ET in accordance with the PPNNE Medical Protocol.
2) Manage routine hormonal contraceptive and HT/ET problems.
3) 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.
3) 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.
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.

I. 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.

- 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.
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

Amy Borgman
Print Name

Amy S Borgman 3·16·07
Signature Date

Collaborating Physician: Cheryl Gibson, MD, Medical Director

2008

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 Boxman (Last) Kym (First) M (Middle)

Mailing Address Planned Parenthood (Office Name)
183 Talcott Road (Street)
Williston, VT. 05495 (City/State) (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042.0010

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Healthcare	Burlington, VT.	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Borgman, August Burns, Johanna Hauser, Katra Kindar
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 activities of Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

2/16/07 (Date)

(Signature of Secondary Supervising Physician)

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 21st day of February, A.D. 2007

Tracy Hayes

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

PART I

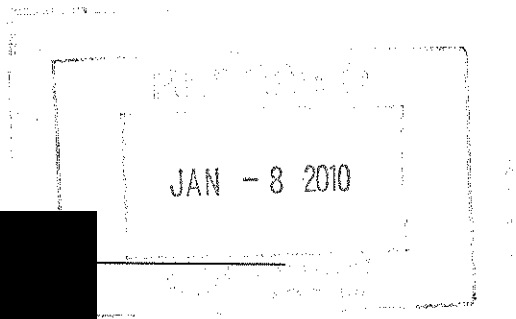
Certificate #055-0030098

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. Work Address:

PPNNE
183 Talcott Road
WILLISTON VT 05495



4. Home Address: [redacted]

City, State, Zip Code:

Please check your preferred mailing address: ☐ Home ☑ Work
(This address will be public and listed on the Board's website)

5. Email Address: [redacted]

6. Daytime Telephone Number: Area Code:

(802) 476-6696

7. Date of Birth: [redacted]

8. Place of Birth: [redacted]

9. Certification Examination Taken – (Check box and enter date of examination):

☑ (10/15/07) 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):

12. In what year did you start working as a physician assistant in Vermont? 1986

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:
NH

15. States where you previously were certified or licensed to practice:
VIRGINIA

16. Specialty: GYN DEA Number: MB0763234

17. Name and office address of current EMPLOYER:

Name Address
Planned Parenthood of Northern New England 183 TALCOTT RD WILLISTON VT 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 Address
Dr Cheryl Gibson 23 MANSFIELD AVE BURL VT 05401

Secondary Supervising Physician(s):

Name Address
Susan Smith 23 Mansfield Ave Burl, VT. 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.

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 - 47 require an explanation on Form A.

23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
□ yes ☑ no

24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
□ yes ☑ no

25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
□ yes ☑ no

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

27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes ☑ no

28. Have you ever discontinued your education, training, or practice for a period of more than three months?
□ yes ☑ no

29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes ☑ no

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

31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
□ yes ☑ no

32. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.
□ yes ☑ no

33. Are you presently or have you ever been a defendant in a criminal proceeding?
□ yes ☑ no

PART III

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

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

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

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

The following definitions are provided to assist you in answering questions 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? [redacted]

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

37. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs [redacted] 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? [redacted]

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

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 "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 complete copies of documentation for each matter.**

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

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

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

(Date) (Final Disposition - Summary)

42. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]
☑ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide complete copies of documentation for each matter.**

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

43. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☑ Check here if none

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 complete copies of documentation for each matter.**

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

B. Other Restrictions ☑ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

(Nature of Action) (Action)
☐ In lieu ☐ In settlement
(Reason for Action)

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

A. Judgments ☑ Check here if none

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

None reported

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☑ Check here if none

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

None reported

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

45. Years of Practice [See 26 VSA § 1368(a)(10)] ~~1982~~

What month and year did you start practicing as a Physician Assistant? August 1983

46. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #46 is optional. By answering, you re granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

UVM COLLEGE OF NURSING Burlington VT Adjunct Faculty 9/09 → 5/10

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

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

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year)	To (year)
UVM School of Nursing	Barre	VT	PRECEPTOR	2006	present

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

Note: Answering #47 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.

None reported

(Title)	(Publication)	(Year)
(Title)	(Publication)	(Year)

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

Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

None reported

(Activities or Awards)

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

What is the location of your primary practice setting? **Barre, VT**

90 washington st. 05641

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? ☒ Yes ☐ No

If yes, please describe the translating services available: **None**

Availability of Professional translating services

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

A. Medicaid participation
Do you participate in the Medicaid program? ☑ Yes ☐ No

B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☑ Yes ☐ No

Part V

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: 11-16-09

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

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 (City/State) (Zip Code) 863-9001 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen HealthCare	Burlington	ob/gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call service/backed up by two MD's.

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 Amy Bergman, P.A. while under my supervision. I further certify that the protocol outlining 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 (Date)

(Signature of Supervising Physician)

Co-signature of PA:

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

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 (Last) Susan (First) — (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 (City/State) (Zip Code) 863-9001 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Bergman 90 Washington St. Barre, VT.
Johanna Hauser 23 Mansfield Ave. Burl, VT.
Anne Hildreth 6 Roberts No. Rutland, VT. (over) →

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 Amy Bergman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

12/29/09 (Date)

X Susan Smith (Signature of Secondary Supervising Physician)

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 Bayman (Last) Kym (First) M (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 863-9001
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042001059?

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Boreman 90 Washington St. Barre, VT.
Johanna Hauser 23 Mansfield Ave. Burl. VT.
Anne Hildreth 6 Roberts NO. Rutland, VT.

OVER →

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 Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

1-5-10
(Date)

(Signature of Secondary Supervising 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.

Code of Conduct for
Certified and Certifying PAs

Planned Parenthood®
of Northern New England

serving
Maine,
New Hampshire,
& Vermont

CENTRAL OFFICE
183 Talcott Road, Suite 101, Williston, VT 05495
Phone 802-878-7232 ■ 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 Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by 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 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 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.

Physician Assistant — Date: 12.16.09

Amy Bergman

Supervising Physician — Date: 12/22/09

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.

B. 1) Order and dispense hormonal contraceptives and HT/ET in accordance with the PPNNE Medical Protocol.
2) Manage routine hormonal contraceptive and HT/ET problems.
3) 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.
3) 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.
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.

I. 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.
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

Amy Bergman
Print Name

X
Signature

2.24.09
Date

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.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 11-16-09

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: _____

Date: 11.16.09

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.

☐ I consent _____ _____

Signature Date

_____ _____

Print Name Vermont License or Certification Number

Print Mailing Address _____

_____

Telephone _____

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

RD 170.00

2012 PHYSICIAN ASSISTANT LICENSURE RENEWAL APPLICATION

PART I

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 ~~VT~~ 05641

108 Lakeside Ave, Suite 301, Burl, VT 05401

4. Home Address: _____ [redacted]

City, State, Zip Code: _____

5. Email Address: _____

6. Daytime Telephone Number: Area Code:

(802) 476-6696

RECEIVED
JAN - 9 2012

7. Date of Birth: [redacted]

8. Place of Birth: _____ [redacted]

9. Certification Examination Taken – (Check box and enter date of examination):

- ☒ (10/15/07) 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):

_____
_____
_____
_____

12. In what year did you start working as a physician assistant in Vermont? 1986

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:
New Hampshire

15. States where you previously were certified or licensed to practice:
New Hampshire, VIRGINIA

16. Specialty: FAMILY PLANNING DEA Number: MB0763234

17. Name and office address of current EMPLOYER(S):

PPNNE, ~~23 Mansfield Avenue~~, Burlington, VT 05401
128 LAKESIDE AVE
Name SUITE 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 Address
Regan Theilen PPNNE 183 St Paul St Burl VT 05401

Secondary Supervising Physician(s):

Name Address
Renee Novello PPNNE 6 Roberts North Rutland VT 05701

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.

a. Has there been a change in your delegation agreement 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.

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 - 47 require an explanation on Form A.

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

☒ yes □ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

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

The following definitions are provided to assist you in answering questions 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?

[redacted]

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

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?

[redacted]

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

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

[redacted]

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

IMPORTANT

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

Part IV - Statutory Profile Questions

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

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

39. Criminal Convictions [See 26 VSA § 1368(a)(1)] ☒ 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 RPR 1/12/12

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 complete copies of documentation for each matter.**

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

41. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)] ☒ Check here if none RPR 1/12/12

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)

42. Licensing or Certification Authority Matters in Other States [See 26 VSA § 1368(a)(4)]
☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide complete copies of documentation for each matter.**

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

43. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☒ Check here if none

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 complete copies of documentation for each matter.**

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

B. Other Restrictions ☒ Check here if none RPR 1/12/12

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.**

(Date) (Hospital) (State)

(Nature of Action) (Action) _____ ☐ In lieu
☐ In settlement
(Reason for Action)

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

A. Judgments ☒ Check here if none RRK 1/12/12

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

None reported

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☒ Check here if none

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

None reported

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

45. Years of Practice [See 26 VSA § 1368(a)(10)] **1982**

What month and year did you start practicing as a Physician Assistant? Sept. 1982 ~~1984~~

46. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #46 is optional. By answering, you re granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

UVM Burl VT Adjunct Prof. 6/09 → 12/11

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching

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

UVM Burl VT preceptor 6/04 → 6/12/11

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

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

Note: Answering #47 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.

None reported

(Publication) (Year) (Title)

(Publication) (Year) (Title)

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

Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

None reported

(Activities or Awards)

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

What is the location of your primary practice setting? **Barre, VT**

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? ☒ Yes ☐ No

If yes, please describe the translating services available: **None**

These are contracted out

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

A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V

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: 11.20.11

Applicant's Signature

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

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 23 and 24)Withdrawal or denial of License - Attach documents

State VERMONT Year 2011
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated

N/A

(Question 25) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State _____ Year _____

Circumstances _____

(Question 26) Disciplinary charges or action - Attach documents

Name of organization involved _____ Date _____

Duration _____

Action taken (circle all that apply)

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

Circumstances _____

(Question 27) Denial of examination privileges - Attach documents

State _____ Year _____

Circumstances under which examination privileges denied _____

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

Residency Training Program(s) Work @ Bame PPNNE

Location of Programs _____ Year _____

Circumstances Maternity leave of 4 months x2: 12/90 → 3/92

6/92 → 10/92

(Question 30) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 31) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Question 32) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

(Questions 33 and 35) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 34) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 36-38) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

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

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 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)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

_____

_____

_____

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Theiler (Last) Regan (First) Nell (Middle)

Mailing Address Planned Parenthood of Northern New England (Office Name)
183 St. Paul Street (Street)
Burlington, VT (City/State) 05401 (Zip Code) 802-863-6326 (Telephone Number)

Vermont License #: 042-0012264

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	111 Colchester Ave. Burlington, VT 05401	OB/GYN

What arrangements have you made for supervision when you are not available or out of town:
24/7 on call service

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 Amy Borgman, P.A. while under my supervision. I further certify that the protocol outlining 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.

12/2/11 (Date)

(Signature of Supervising Physician)

Co-signature of PA:

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

055-003098

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello (Last) Renee (First) J. (Middle)

Mailing Address Planned Parenthood of Northern New England (Office Name)
6 Roberts North (Street)
Rutland, VT (City/State) 05701-3120 (Zip Code) 802-775-2333 (Telephone Number)

Vermont License #: 042-0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Mt. Ascutney Hospital and Health Center	289 County Road Windsor, VT 05089	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Borgman, 90 Washington St. Barre, VT 05641
August Burns, 213 E. Main St. Hyde Park, VT 05655
Johanna Hauser, 183 St. Paul St., Burlington, VT 05401

→over

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 Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and hat in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

12/15/11 (Date)

R Novello (Signature of Secondary Supervising Physician)

055-0030098

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

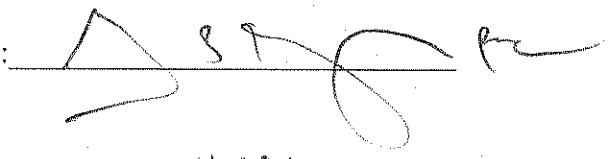
I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

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: 

Date: 11-18-11

Amy Borgman
055-0030098

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)

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

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

or

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

Regarding Taxes

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

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

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

or

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

☐

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 11.18.11

Amy Borgman
055-003098

Planned Parenthood®
of Northern New England

serving
Maine,
New Hampshire,
& Vermont

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

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

1) PPNNE Standing Orders: Each P.A 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 at PPNNE.

2) 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.

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 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.

Amy Borgman
P.A

1.6.12
Date

Regan Theiler M.D
Supervising Physician

12/2/11
Date

Amy Borgman
055-0030098

NCCPA
National Commission on Certification of Physician Assistants

November 21, 2011

[redacted]

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,

Cindy Nalls

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.

055-00300988

12000 Findley Road • Suite 100 • Johns Creek • Georgia • 30097 • Tel: 678.417.8100 • Fax: 678.417.8135 • Web: www.nccpa.net

VERMONT

Amy Borgman PA-C
[redacted]

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

Application

Part I
- ☐ Item 1
- ☐ Item 2
- ☐ Item 3
- ☐ Item 4
- ☐ Item 5
- ☐ Item 6
- ☐ Item 7
- ☐ Item 8
- ☐ Item 9
- ☐ Item 10
- ☐ Item 11
- ☐ Item 12
- ☐ Item 13
- ☐ Item 14
- ☐ Item 15
- ☐ Item 16
- ☐ Item 17
- ☐ Item 18
- ☐ Item 19
- ☐ Item 20

Part II
- ☐ Item 21
- ☐ Item 22
- ☐ Item 23
- ☐ Item 24
- ☐ Item 25
- ☐ Item 26
- ☐ Item 27
- ☐ Item 28
- ☐ Item 29
- ☐ Item 30
- ☐ Item 31
- ☐ Item 32

Part III
- ☐ Item 33
- ☐ Item 34
- ☐ Item 35
- ☐ Item 36
- ☐ Item 37

Part IV
- ☐ Item 38
- ☐ Item 39
- ☑ Item 40
- ☑ Item 41
- ☐ Item 42
- ☐ Item 43A
- ☑ Item 43B
- ☑ Item 44A
- ☐ Item 44B
- ☐ Item 45
- ☐ Item 46A
- ☐ Item 46B
- ☐ Item 47
- ☐ Item 48
- ☐ Item 49
- ☐ Item 50
- ☐ Item 51A
- ☐ Item 51B

Part V
- ☐ Date
- ☐ Signature

Child Support, Taxes, Unemployment Compensation Statement
- ☐ Number 1 – check one of the two statements
- ☐ Number 2 – check one of the two statements

- ☐ Completed form A
- ☐ Completed Statement of Good Standing

Supervising Physician Forms
- ☐ Primary Supervising Physician Application
- ☐ Secondary Supervising Physician Application(s)
- ☐ Delegation Agreement

NCCPA Certification
- ☐ Proof of NCCPA Certification

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

200048

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Theiler (Last) Regan (First) Nell (Middle)

Mailing Address 23 Mansfield Avenue (Office Name)

(Street)

Burlington (City/State) VT 05401 (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0012264

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Application in process with F.A.H.C		OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call service

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 Amy Borgman, P.A. while under my supervision. I further certify that the protocol outlining 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.

8/2/11 (Date)

X (Signature of Supervising Physician)

X Co-signature of PA:

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

300984

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

RECEIVED
APR 25 2011

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Toivanen (Last) Kathleen (First) Marie (Middle)

Mailing Address Planned Parenthood (Office Name)
183 Talcott RD (Street)
Williston VT 05401 (City/State) (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042-0012163

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Portsmouth Regional Hospital	Portsmouth, NH	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call service

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 Amy Borgman, P.A. while under my supervision. I further certify that the protocol outlining 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.

4/11/11 (Date)

X Kathleen M. Toivanen (Signature of Supervising Physician)

Co-signature of PA: X

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello Renee
(Last) (First) (Middle)

Mailing Address Planned Parenthood
(Office Name)
183 Talcott Road
(Street)
Williston, VT. 05495 288-8432
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042-0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Mt. Ascutney Hospital	Windsor, VT.	OB/Gyn
DHMC	Lebanon, NH	OB/Gyn

List all physician's assistants names and addresses you currently supervise:
Johanna Hauser 23 Mansfield Ave. Burlington, VT.
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 activities of Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

4/13/11
(Date)

X R Novello
(Signature of Secondary Supervising Physician)

MAR 29 2011

30098

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello (Last) Renee (First) — (Middle)

Mailing Address Planned Parenthood (Office Name)
6 Roberts North (Street)
Rutland, VT. 05701 775-2333
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042001195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
MT. Ascutney Hospital	Windsor, VT.	OB/Gyn
DHMC	Lebanon, NH	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call service

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 Amy Bargman, P.A. while under my supervision. I further certify that the protocol outlining 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.

3/4/2011 (Date)

X [signature] (Signature of Supervising Physician)

Co-signature of PA: X [signature]

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

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 Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
183 Talcott RD. (Street)
Williston, VT (City/State) 05495 (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042000 7465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/Gyn

List all physician's assistants names and addresses you currently supervise:
Amy Borgman 90 Washington St. Barre, VT. 05641
Johanna Hauser 23 Mansfield Ave. Burlington, VT. 05401
Anne Hildreth 6 Roberts No. Rutland, VT. 05701

(OVER) →

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 Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

3/3/11 (Date)

X _____ (Signature of Secondary Supervising Physician)

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello (Last) Renee (First) (Middle)

Mailing Address Planned Parenthood (Office Name)
6 Roberts North (Street)
Rutland, VT. 05701 (City/State) 775-2333 (Zip Code) (Telephone Number)

Vermont License #: 042.0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
MT. Ascutney Hospital	Windsor, VT.	OB/Gyn
Dartmouth Hitchcock med. ctr	Lebanon, NH	OB/Gyn

List all physician's assistants names and addresses you currently supervise:

Janet Young	23 Mansfield Ave. Burlington, VT. 05401			
Johanna Hauser	"	"	"	"
Catherine Nicholas	"	"	"	"
Sarah Vensel	"	"	"	" (ONEE)

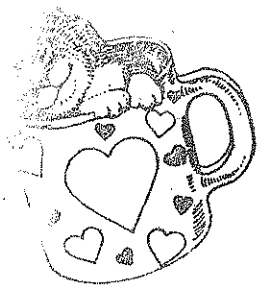
CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Amy Boraman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

11/16/10 (Date)

(Signature of Secondary Supervising Physician)



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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Burkett (Last) Donna (First) (Middle)

Mailing Address Planned Parenthood of NNE (Office Name)
128 Lakeside Ave, Suite 301 (Street)
Burlington, VT (City/State) 05401 (Zip Code) 802-448-9717 (Telephone Number)

Vermont License #: 042.0012729

Pending – Hospital(s) where you have privileges: Fletcher Allen | Hospital(s) Location: Burlington, VT | Specialty: Family Practice

What arrangements have you made for supervision when you are not available or out of town:
Strong relationship with UVM + FAHC Family Medicine + OB/GYN departments, who will care for patients in the rare instance they need hospitalization + I am not available.

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 Amy Borgman, P.A. while under my supervision. I further certify that the protocol outlining 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.

12/19/13 (Date)

(Signature of Supervising Physician)

Co-signature of PA:

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MB0763234

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello (Last) Renee (First) (Middle)

Mailing Address Planned Parenthood of Northern New England (Office Name)
128 Lakeside Ave, Suite 301 (Street)
Burlington (City/State) VT 05401 (Zip Code) 802-448-9719 (Telephone Number)

Vermont License #: 042-0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Dartmouth Hitchcock	Lebanon, New Hampshire	OB/GYN

List all physician's assistants names and addresses you currently supervise:

Amy Corey	80 Fairfield St, St. Albans, VT 05478
Erin Haynes	4 Bowdoin Mill Island, Ste 101, Topsham, ME 04086
Anne Hildreth	6 Roberts Ave, Rutland, VT 05701
Jennifer Moriarty-Loeun	24 Pennacook St, Manchester, NH 03104

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Amy Borgman, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 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.

12/15/13 (Date)

(Signature of Secondary Supervising Physician)

nccpa
Certification. Excellence.

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,

Cindy Nalls

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.

Planned Parenthood of Northern New England

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.

Planned Parenthood of Northern New England

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).

MB0763234
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.

Amy S Borgman PA		1.10.14
Print Name	Signature	Date
Donna Burkett, MD		1-9-14
Collaborating Physician/Medical Director	Signature	Date

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	

5. Enter your MAILING ADDRESS information:

Attention

Street [redacted]

City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States

E-mail Address

Telephone **Alternate Phone (e.g. Pager)**

6. Enter your PUBLIC ACCESS address information:

Attention PPNNE

Street 128 Lakeside Avenue

City Burlington **State** VT **Zip** 05401

Country United States

Telephone (802) 476-6696

E-mail Address [redacted]

Alternate Phone (e.g. Pager)

7. Date of Birth: [redacted]

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

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)?
No

43. Name of organization involved:

44. Date:

45. Duration:

46. Action Taken (add all that apply):

47. Circumstances:

48. Disciplinary charges or actions - Upload documents:

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

50. State:

51. Circumstances under which examination privileges denied:

52. Denial of examination privileges - Upload documents:

53. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
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:

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

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

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

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

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

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

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

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 802-223-0400 (a confidential line).

Renewal Part IV

Statutory Profile Questions

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

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

No

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

Date of Conviction	Court of Conviction	City	State	Description

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?

No

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

Date of Charges	Court	City	State	Description of Charges

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

No

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

Date	Final Disposition Summary

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

No

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

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

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

No

113.
A. Revocation/Involuntary Restrictions
Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or

character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please upload copies of papers fully documenting these matters.

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

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

No

115.

B. Other Restrictions

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

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

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

No

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.

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

Date Of Settlement

Medical Malpractice Claim

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

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. Teaching

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

School / Institution	City	State	Nature of Teaching	Date Started	Date Ended
University of Vermont	Burlington	Vermont	Preceptor	06/01/2004	12/01/2011

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

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your 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	State	Primary Practice	Languages	Accepts Medicaid?	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 must select one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

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

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:
[redacted]

131. Date of Birth:
[redacted]

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 privileges in Vermont? _____ Yes ___✓___ No
Name(s) and Location(s) of Hospital(s): _____

14. Did you practice in Vermont during the past 12 months? ___✓___ Yes ____No

15. Other states where you now hold an active certification or license to practice: _____
16. States where you previously were certified or licensed to practice: VIRGINIA

17. Specialty: G Y N DEA Number: _____

18. Name and office address of current employer:

Name	Address
PPNNE	90 WASHINGTON ST BARRE VT 05641

19. Name, specialty and office address of Supervising Physician(s):

Name	Specialty	Address
Judy Tyson MD	GYN	c/o PPNNE 23 MANSFIELD AVE BARRE VT 05401

20. Name, specialty and office address of the Secondary Supervising Physician(s):

Name	Specialty	Address
Cheryl Gibson MD	GYN	c/o WOMEN'S CHOICE 23 MANSFIELD AVE BARRE VT 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.

1. 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, resid[redacted]

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

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? [redacted]

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)? ____ YES ✓ NO

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)? See Form A ✓ YES ____ NO

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? ____ YES ✓ NO

8. Have you ever voluntarily surrendered or resigned a license to practice as a physician's assistant or any healing art? ____ YES ✓ NO

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 ✓ NO

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

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? ____ YES ✓ NO

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

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 or elsewhere? ____ YES ✓ NO

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

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FOUR OF FIVE

SECTION III

1. What is the date you started practicing as a physician's assistant (excluding residency training)?
(Month/Year) 6/82

2. What is the date you started practicing as a physician's assistant **in Vermont** (excluding residency training)?
(Month/Year) 9/86

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

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

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

4. Practice Site Number One
Street Address: 90 WASHINGTON ST
Town: BARRE VT Zip: 05641

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
Family Planning	7-15	12	No	Yes	~30%	Yes	<1%	Yes

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

5. Practice Site Number Two
Street Address: 41 S. Main St Town: RANDOLPH Zip: 05060

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
Family Planning	6-8	12	No	YES	30-40%	Yes	?	Yes

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

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.

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

APPLICANT'S STATEMENT REGARDING TAXES

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

OR

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

STATEMENT OF APPLICANT

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

Social Security Number: [redacted]

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

Date: 1-24-94 **Signature:** _____

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

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

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

IMPORTANT: Please be sure to write your 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: Amy S. Borgman

Insurer: Planned Protection Insurance Co, Ltd.

Claimant Name: Nyra Whipple

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

Basis Code: D 0 9 Basis Code: _____

Basis Code: _____ Basis Code: _____

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

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

PLEASE NOTE: Submission of copies of pertinent medical records will be necessary in some instances.

Incident Location (circle one):

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

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A 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
(02) PA 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

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

Name: S. Crocker Bennett II

Firm: PAUL FRANK & Collins, Inc

Address: 1 Church St

City, State, Zip: Burlington VT 05402

Telephone Number: (802) 658-0042

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

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

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

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

case is pending

Table I for Section A on the next page

Re: Amy S. Bergeron
#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

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

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

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

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

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

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

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

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

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

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

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE FOUR OF SIX

SECTION B: CRIMINAL PROCEEDING - ATTACH DOCUMENTS

Court: _____ Charge: _____ Date: _____

Description: _____

_____

_____

_____

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

SECTION C: DISCIPLINARY CHARGES OR ACTION - ATTACH DOCUMENTS

Name of Organization Involved: _____ Date: _____

Duration: _____

Action Taken (circle all that apply):

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

Circumstances: _____

_____

_____

_____

SECTION D: PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES - 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: WITHDRAWAL OR DENIAL OF LICENSE OR CERTIFICATION- ATTACH DOCUMENTS

State: _____ Year: _____

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

_____

_____

SECTION F: INVESTIGATION BY ANY OTHER LICENSING BOARD - ATTACH DOCUMENTS

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

_____

_____

SECTION G: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED - ATTACH DOCUMENTS

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

_____

SECTION H: TREATMENT FOR EMOTIONAL DISTURBANCE OR MENTAL ILLNESS, ORGANIC ILLNESS, ALCOHOL OR DRUG DEPENDENCY

Treating Organization: _____

Address: _____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

_____

_____

Dates of Illness/Dependency: _____ to _____

Dates of Treatment: _____ to _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A 1994-1996 PHYSICIAN'S ASSISTANT CERTIFICATION RENEWAL APPLICATION, PAGE SIX OF SIX

SECTION I: AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT ATTACH DOCUMENTS

Institution Involved: _____

Date: _____

Circumstances: _____

_____

_____

SECTION J: VOLUNTARILY SURRENDERED OR RESIGNED CERTIFICATION OR LICENSE TO PRACTICE AS A PHYSICIAN'S ASSISTANT OR ANY HEALING ART - ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances: _____

_____

_____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

SECTION L: TURNED DOWN FOR COVERAGE BY MALPRACTICE INSURANCE CARRIER - ATTACH DOCUMENTS

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____

_____

SECTION M: SEVERITY LEVEL III NOTICE BY PEER REVIEW ORGANIZATION (PRO) - ATTACH DOCUMENTS

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

_____

_____

_____

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

David L. Glazer

Executive Vice President and Managing Director

47535-93

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

TOTAL FORMS & SYSTEMS (404) 447-9917

86554

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
[redacted]

NATIONAL COMMISSION
ON
CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

AMY S. BORGMAN

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

PHYSICIAN ASSISTANT-CERTIFIED and PA-C

Certificate No.: 830420

Expiration Date: 06/01/95

David L. Glazer

Executive Vice President 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

ATULATIONS. 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 CPA certificate for the current two-year period.

Hours
CCPA:
JUNE 2, 1993 (PERIOD 6/91 - 6/93).

MS. AMY S. BORGMAN PA-C
[redacted]

	Hours logged to date for this reregistration period	Hours remaining to log for this reregistration period
CATEGORY I	69	
CATEGORY II	48	

CENTRAL OFFICE:
51 Talcott Road, #1
Williston, VT 05495

Planned Parenthood® of Northern New England

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

Valerie Wilkins
Assistant to the Associate Director

51 Talcott Road, #1
Williston, VT 05495

Planned Parenthood® of Northern New England

802•878-7232
FAX: 802•878-8001

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

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.
2) Manage routine oral contraceptive problems.
3) 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.
2) 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.
2) 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)
Fenoprofen (Nalfon)
Ferrous Fumarate
Ferrous Gluconate
Ferrous Sulfate
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)

K. 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
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.

TM Sa

Collaborating Physician: Judith Tyson, M.D., Medical Director, PPNNE

I agree to practice under the above standing orders

S. Bo PAc — 1.20.93

Signature — Date