MCHV
Medical Center Hospital of Vermont

August 6, 1986

Board of Medical Practice
Licensing & Registration Division
Redstone
26 terrace Street
Montpelier, Vermont 05652

Re: Cheryl A. Gibson, MD

Dr. Cheryl A. Gibson has satisfactorily completed her Internship at the Medical Center Hopsital of Vermont in the Department of Obstetrics and Gynecology. Her internship began June 22, 1985 and ended June 30, 1986

John D. Lewis, MD
Associate Director
Residency Training Program
Dept. of Ob/Gyn

JDL/vms

(802) 656-2345
Burlington, Vermont 05401
A Vermont Health Foundation Company

VHA
Voluntary Hospitals of America, Inc.

State of Vermont
Board of Medical Practice
Redstone Building, 26 Terrace Street
Mail: Pavilion Office Building
Montpelier, Vermont 05602-2198
(802) 828-2673

Toll Free 1-800-642-5155

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

STATE OF VERMONT

BOARD OF MEDICAL PRACTICE

August 25, 1986

John Van S. Maeck, M.D.
Medical Alumni Association
Vermont College of Medicine
Given Building
Burlington, Vermont 05405

Dear Dr. Maeck:

The completed application for Cheryl Ann Gibson, M.D. has been enclosed for your review.

He will be contacting you to arrange for a personal interview.

Should you have questions or concerns, please do not hesitate to contact this office.

Sincerely yours,

Everen Farnham

Everen Farnham, Office Secretary
Vermont Board of Medical Practice

State of Vermont
Board of Medical Practice
Redstone Building, 26 Terrace Street
Mail: Pavilion Office Building
Montpelier, Vermont 05602-2198
(802) 828-2673

Toll Free 1-800-642-5155

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

STATE OF VERMONT

BOARD OF MEDICAL PRACTICE

August 25, 1986

Cheryl Ann Gibson, M.D.
[redacted]

Dear Dr. Gibson:

Your application for medical licensure appears to be complete. It now becomes your responsibility to contact John Van S. Maeck, M.D. to arrange for your personal interview.

Dr. Maeck's address is Medical Alumni Association, Vermont College of Medicine, Given Building, Burlington, Vermont 05405. The telephone number is 802-656-4093.

The full Board will act upon your request for licensure at their first, regularly scheduled meeting following your interview. The Board of Medical Practice usually meets on the second Wednesday of each month.

Should you have further questions or concerns, please do not hesitate to contact this office.

Sincerely yours,

Everen Farnham

Everen Farnham, Office Secretary
Vermont Board of Medical Practice

STATE OF VERMONT BOARD OF MEDICAL PRACTICE

APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT

Please submit in typewritten form only. Incomplete applications will be returned. When space provided is insufficient, attach additional sheets. All documents must be received within six (6) months or the application becomes invalid.

SECTION I

#7465

Must be Completed By All Applicants

Name in full Gibson (Last) Cheryl (First) Ann (Middle) (Maiden)

Name as you want it to appear on your license certificate:

Cheryl A. Gibson MD

Have you ever legally changed your name? no If so, enclose a certified copy of the legal document stating the change.

Mailing Address [redacted]

Office Address Medical Ctr. Hosp. of Vt. (street) Burlington (city) Vermont (state) 05401 (zip code) 802-656-2345 (phone)

Date of Birth [redacted] Place of Birth [redacted]

****

PREMEDICAL EDUCATION

University of Vermont Burlington, Vermont Sept. 1972-May 1977 BS
(Name and location of institute) (From/To) (Degree)

(Name and location of institute) (From/To) (Degree)

****

MEDICAL EDUCATION - See also Section II

Univ. of Vermont College of Medicine Burlington 9/81-5/85 MD
(Name and location of institute) (From/To) (Degree)

(Name and location of institute) (From/To) (Degree)

****

Training: List chronologically residency or other post-graduate training. Give name, address of hospitals, exact dates, and type of training. Include COPIES OF CERTIFICATES.

Name	Address	From/To	Training
Medical Ctr. Hosp of Vermont	Burlington	6/85-present	OB/GYN residency

****

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

Name	Address	From/To	Training
none			

****

Have you ever held a Vermont Limited Temporary License? yes If so, # L1293

Do you hold or have you ever held a medical license in any other state? no If yes, complete below and also Section III.

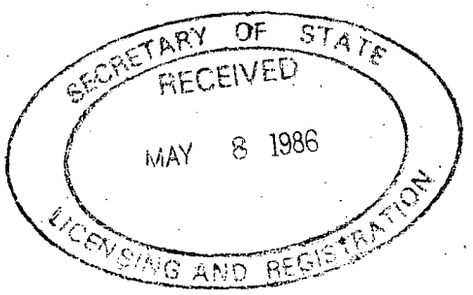
State	License #	Date Issued	Status

****

Specialty areas in which you practice medicine. Obstetrics and gynecology

Are you Board Certified? no If yes, enclose a copy of Board Certificate.

FOREIGN GRADUATES: ECFMG Standard Certificate# _____ Date Issued _____
A certified copy of your ECFMG CERTIFICATE must accompany this application.



FLEX: Have you ever taken the FLEX examination? no

Date	State	Passed/Failed
Date	State	Passed/Failed

NATIONAL BOARDS: Have you taken the National Boards? yes If yes, have a certified copy of your results forwarded to this office by the National Board of Medical Examiners. (See enclosed card.)

****

1) Have your previously applied for a license in Vermont? Yes_____ No x
   If yes: Under what name. _____ Year_____

2) Have you ever applied for and been denied a license in another state?
   Yes_____ No x

3) Have your hospital privileges ever been denied, conditioned, or revoked?
   Yes_____ No x

4) Do you now hold or have you ever held a medical license that has been subject to disciplinary proceedings before any state board of medical practice or had a license suspended, revoked, or limited in any way?
   Yes_____ No x

5) Have you ever been convicted of a criminal offense, other than minor traffic violations?
   Yes_____ No x

6) Have you ever received care for an emotional or mental problem?
   [redacted]

7) Have you ever had or do you now have a problem with drug addiction, alcoholism, or both?
   [redacted]

8) Have you ever had any malpractice judgments against you?
   Yes_____ No x

IF THE ANSWER TO ANY OF THESE QUESTIONS (#'s 1 thru 8) IS YES, PLEASE IDENTIFY BY NUMBER AND EXPLAIN FULLY USING A SEPARATE SHEET.

****

In which part of the state would you prefer to be interviewed? (Southern, Central, etc.) _____

Northern

****

Attach photo taken within the last 60 days(head and shoulders). Proofs not acceptable.

Sign front of photo.

AFFIDAVIT OF APPLICANT

I, Cheryl A. Gibson MD, say that I am the person, referred to in the foregoing application and supported by the attached photograph is a true likeness of myself.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct.

Should I furnish any false information on this application, I hereby agree that such an act shall constitute cause for denial of my license to practice medicine in the State of Vermont.

5/5/86
Date

Signature of Applicant

Subscribed and sworn to before me this 5 day of May, 1986

County of Chittenden

State of Vermont

My Commission Expires 2/10/87

Notary Public

****

FOR OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

Application received _____ License # _____

Interviewer: _____ Forwarded _____

Approved by: _____ Date: _____

SECRETARY OF STATE
RECEIVED
MAY 8 1986
LICENSING AND REGISTRATION

SECTION II

Must Be Completed By All Applicants

CERTIFICATE OF MEDICAL EDUCATION
To be completed by an officer of your School of Medicine

I hereby certify that Cheryl A Gibson MD (Name) was admitted to the University of Vermont School of Medicine in Burlington, Vermont 05405 (City and State) on August 31, 1981 (Date)

and completed all requirements for graduation on 4/30/85 (Date).

A Doctor of Medicine (Specify certificate/diploma/degree) was granted on May 18, 1985 (Date).

(SEAL)

Date May 8, 1986 Signed _____.
Authorized Officer of the School
David M. Tormey, M.D.
Associate Dean for Admissions,
Student Affairs and Alumni
Relations

Please forward completed form to:

Board of Medical Practice
c/o Secretary of State's Office
State Office Building
Montpelier, VT 05602

State of Vermont
Board of Medical Practice
Redstone Building, 26 Terrace Street
Mail: State Office Building
Montpelier, Vermont 05602-2198
(802) 828-2673
Toll Free 1-800-642-5155

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

June 25, 1986

Cheryl A. Gibson, M.D.
[redacted]

Dear Dr. Gibson:

This letter is in regards to your application for medical licensure in the State of Vermont.

At the present time you are missing the following documentation from your application file.

Certified copy of your medical school diploma
Copy of your post-graduate certificate
One reference letter, we have letters from Drs. Riddick and Reardon

When these documents have been received by this office, I will be contacting you as to a physician member of the Vermont Board of Medical Practice to contact for a personal interview.

Should you have questions or concerns, please feel free to contact this office.

Sincerely yours,

Everen Farnham

Everen Farnham
Office Secretary
Vermont Board of Medical Practice

EVF/me

State of Vermont
Board of Medical Practice
Redstone Building, 26 Terrace Street
Mail: State Office Building
Montpelier, Vermont 05602-2198
(802) 828-2673
Toll Free 1-800-642-5155

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

May 26, 1986

RE: Medical licensure application

Dear Dr. Gibson:

The Vermont State Board of Medical Practice has received your application for medical licensure. The following documents have not yet been received by this office. (See checked items.)

_____ Certified copy of your birth certificate.

_X_ Notarized copy of your medical school diploma.

_____ Section II, "Certificate of Medical Education:. This must be sent to your medical school and be returned directly to this office.

_____ Notarized copy of your ECFMG certificate. This must be a valid certificate, check your expiration date.

_____ Section III, "Certificate of Medical Licensure" from _____

_X_ FLEX scores, even if you took the examination in Vermont, the Board requires these scores be sent to us directly from the FLEX or National Board examining agency.

_____ Notarized copy of your Specialty Board Certificate.

_X_ Post graduate certificate

_____ Two letters of recommendation, we have letters from Riddick

THANK YOU FOR YOUR PROMPT ATTENTION TO THIS MATTER.

State of Vermont
Board of Medical Practice
Redstone Building, 26 Terrace Street
Mail: Pavilion Office Building
Montpelier, Vermont 05602-2198
(802) 828-2673

Toll Free 1-800-642-5155

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

STATE OF VERMONT

BOARD OF MEDICAL PRACTICE

September 18, 1986

Cheryl A. Gibson, M.D.
[redacted]

RE: Vermont Medical License
#42-0007465

Dear Dr. Gibson:

On Wednesday, September 10, 1986, by unanimous vote of the Board of Medical Practice, you were granted a Vermont Medical License. Please note your license number indicated above.

A wall certificate and registration card have been ordered and will be sent to under separate cover. All medical licenses must be renewed annually on or before January 31st and you will receive a notification annually in December.

Please let us know if you have questions or concerns.

Sincerely yours,

Everen Farnham

Everen Farnham
Office Secretary
Vermont Board of Medical Practice

EVF/me

The University of Vermont

To all to whom these presents may come, sendeth greetings

Whereas the Faculty of the College and the University Senate have recommended

Cheryl Ann Gibson, B.S.

as having completed the Studies assigned and passed the Examinations required, We, the Trustees of the University by virtue of the authority vested in us do hereby confer upon her the Degree of

Doctor of Medicine

and admit her to all the rights, privileges and honors appertaining thereto

In Witness Whereof, the seal of the University and the signature of the President the Dean and the Secretary are hereunto affixed.

Given at Burlington, Vermont on the eighteenth day of May in the year of our Lord, One Thousand Nine Hundred and Eighty-Five and of the University the One Hundred and Ninety-Fourth.

William H. Lillimbrahl

Secretary of the Board of Trustees

Notary Public
July 22, 1986

The University of Vermont

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
MEDICAL CENTER HOSPITAL OF VERMONT
MARY FLETCHER UNIT
BURLINGTON, VERMONT 05401

May 5, 1986

State of Vermont
Board of Medical Practice
State Office Building
Montpelier, VT 05602

Dear Sir or Madam: RE: Cheryl A. Gibson, M.D.

Dr. Cheryl Gibson, who is applying for licensure in the State of Vermont, is currently a resident in Obstetrics and Gynecology at the Medical Center Hospital of Vermont. She has proven to be a competent physician, sensitive to patient needs, and has done very well in the Operating Room. I fully support her application for licensure.

If I can provide you with any additional information, please do not hesitate to let me know.

With best regards.

Sincerely yours,

Daniel H. Riddick, M.D., Ph.D.
Professor and Chairman

DHR/ds

INTERNAL MEDICINE
Peter D. Alden, M.D.
Jonathan B. Hayden, M.D.
Edward S. Leib, M.D.
Thomas W. Martenis, M.D.
John H. Milne, M.D.
Mildred A. Reardon, M.D.
Michael J. Scollins, M.D.

Aesculapius Medical Center
ONE TIMBER LANE • SOUTH BURLINGTON, VERMONT 05401
TELEPHONE: 802—658-4714

May 21, 1986

State of Vermont
Board of Medical Practice
Pavilion Building
Montpelier, Vermont 05602

To Whom It May Concern

I am a licensed physician in Vermont and have been since 1968. Over the past several years I have worked with a former medical student, at the University of Vermont College of Medicine and current resident in the program of Ob-Gyn at the Medical Center Hospital of Vermont whose name is Cheryl Gibson. I understand that she is applying for license in the State of Vermont, and I can say after having worked with her with patients, that she does exhibit the skills and integrity we need expect of physicians in Vermont. I support her application for a license to practice medicine in the State of Vermont.

Sincerely,

Mildred A. Reardon

Mildred A. Reardon, M.D.

MAR:sam

Herbert A. Durfee, Jr., M.D.
Acting Chairman
John D. Lewis, M.D.
James F. Clapp III, M.D.
Theodore E. Braun, Jr., M.D.
Philip B. Mead, M.D.
Jerome L. Belinson, M.D.
Mark Gibson, M.D.
Susan F. Smith, M.D.
Eleanor L. Capeless, M.D.
Patrick M. Catalano, M.D.
R. Gerald Pretorius, M.D.
Cynthia A. Farner, M.D.
Francis W. Byrn, M.D.
Emma Wennberg, M.D.

University Associates in
Obstetrics and Gynecology, Inc.
COLLEGE OF MEDICINE
UNIVERSITY OF VERMONT
ONE SOUTH PROSPECT STREET · BURLINGTON, VERMONT 05401
802/658-1472

May 28, 1986

Vermont Board of Medical Practice
Pavilion Office Building
Montpelier, VT 05602

Gentlemen:

RE: Cheryl Ann Gibson, M.D.

It is a pleasure to recommend Cheryl Gibson for permanent licensure as a physician in the State of Vermont.

I have known Cheryl Gibson since the fall of 1976 and have always found her to be of the highest moral character. She has always demonstrated integrity and genuine concern in her dealings both with patients and peers. She will be an excellent addition to the Vermont corps of physicians.

If you have any questions in this regard, please feel free to call me.

Sincerely yours,

Susan Smith

Susan F. Smith, M.D.

SFS:mac

Herbert A. Durfee, Jr., M.D.
Acting Chairman
John D. Lewis, M.D.
James F. Clapp III, M.D.
Theodore E. Braun, Jr., M.D.
Philip B. Mead, M.D.
Jerome L. Belinson, M.D.
Mark Gibson, M.D.
Susan F. Smith, M.D.
Eleanor L. Capeless, M.D.
Patrick M. Catalano, M.D.
R. Gerald Pretorius, M.D.
Cynthia A. Farner, M.D.
Francis W. Byrn, M.D.
Emma Wennberg, M.D.

University Associates in
Obstetrics and Gynecology, Inc.
COLLEGE OF MEDICINE
UNIVERSITY OF VERMONT
ONE SOUTH PROSPECT STREET · BURLINGTON, VERMONT 05401
802/658-1472

May 28, 1986

Vermont Board of Medical Practice
Pavilion Office Building
Montpelier, VT 05602

Gentlemen:

RE: Cheryl Ann Gibson, M.D.

It is a pleasure to recommend Cheryl Gibson for permanent licensure as a physician in the State of Vermont.

I have known Cheryl Gibson since the fall of 1976 and have always found her to be of the highest moral character. She has always demonstrated integrity and genuine concern in her dealings both with patients and peers. She will be an excellent addition to the Vermont corps of physicians.

If you have any questions in this regard, please feel free to call me.

Sincerely yours,

Susan F. Smith, M.D.

SFS:mac

RENEWAL APPLICATION

I hereby apply for the renewal of my LIMITED TEMPORARY LICENSE as a physician for the period of July 1, 1987 to June 30, 1988 under the provisions of Title 26 Chapter 23. I enclose the correct fee of $10.00.

NAME:

60-0001293

GIBSON CHERYL ANN
DEPARTMENT OF OB-GYN
MEDICAL CENTER HOSPITAL.
BURLINGTON, VT 05401

DATE:_____ SIGNATURE:_____

AFFIDAVIT OF SUPERVISING PHYSICIAN

I certify that the above named Doctor is engaged as an intern, resident, fellow or medical officer in the Department of _____

at the _____ Hospital.

I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee while practicing under my supervision.

DATE:_____ SIGNATURE:_____

VERMONT LICENSE #_____

Return completed form to : Board of Medical Practice
Office of the Secretary of State
Licensing & Registration Division
Pavilion Office Building
Montpelier, Vermont 05602

NOTE: RENEWAL APPLICATIONS FOR LIMITED TEMPORARY PERMITS WILL BE APPROVED ONLY IF THE APPLICANT IS ENROLLED IN AN ACGME APPROVED PROGRAM.

RENEWAL APPLICATION

I hereby apply for the renewal of my LIMITED TEMPORARY LICENSE as a physician for the period 7/1/86 to 6/30/87

under the provisions of Title 26 Chapter 23 LICENSE # L-1293

TYPE OR PRINT ONLY

NAME Cheryl A. Gibson, MD

EMPLOYMENT ADDRESS Medical Center Hospital of Vermont

Dept. of Ob/Gyn

Burlington, VT 05401

DATE 6/30/86 SIGNATURE [signature] M.D.

AFFIDAVIT OF SUPERVISING PHYSICIAN

I certify that the said Doctor named in the Renewal Application above is engaged as an interne, resident, fellow or medical officer in the Department of Ob/Gyn at the Medical Center Hospital of Vermont.

I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee while practicing under my supervision.

DATE: 7/7/86 SIGNATURE: [signature] M.D.

VERMONT LICENSE # 42-000 3540

INSTRUCTIONS

"Renewal Application" must be completed and include:

... Dates (One-year contract period)
... License Number
... Name and Employment Address

Be sure to Date and Sign this section

"Affidavit of Supervising Physician" must be completed by and signed by the individual who will be supervising your work at the location indicated in the Renewal Application.

Return completed form to:

Board of Medical Practice
Licensing & Registration Div.
109 State Street
Montpelier, Vermont 05602

VERMONT STATE BOARD OF MEDICAL PRACTICE

APPLICATION FOR LIMITED TEMPORARY LICENSE TO PRACTICE MEDICINE

To the Vermont State Board of Medical Practice:

I hereby make application for a limited temporary license to practice medicine and surgery as an interne, resident, fellow or medical officer in the State of Vermont at the Medical Center Hosp of Vermont Hospital, Department of OB-GYN, under the supervision of JOHN D. LEWIS, M.D., and submit the following information as required by law:

1. Name in full Cheryl Ann Gibson
2. Vermont Address [redacted]
3. Present Address (If Different) —
4. Place of Birth [redacted] 5. Date of Birth [redacted]
6. Have you ever been convicted of a crime other than a minor traffic violation? NO If yes, explain.
7. Have you ever discontinued your education, training or practice for a period of more than three months? NO If yes, explain on back.
8. Education: List chronologically each college or university at which you have been enrolled.

Name	*Location*	*Dates*	*Degree*
University of Vermont	Burlington	1972-1977	BS
University of Vermont	Burlington	1981-1985	MD

9. Training: List chronologically all post-graduate training positions held.

Name of Institution	*Location*	*Dates*
New Jersey College of Medicine	Newark NJ.	1978 -
(Nurse Practitioner Training)		

10. Have you ever been denied a certificate by, or the privilege of taking an examination before any State Medical Examining Board? NO. If yes, explain. _____

11. Do you have a Standard ECFMG Certificate? Part I & II taken - passed If so, attach copy.

12. Have you ever taken the FLEX Examination? NO. If so, where? _____

When _____ Passed or Failed _____

13. Attach a photocopy of your Medical School Diploma. If possible.

DATE: 5-7-85 SIGNED: Cheryl A Gibson M.D.

I, CHERYL ANN GIBSON BEING FIRST DULY SWORN, DEPOSE AND SAY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING APPLICATION AND SUPPORTING DOCUMENTS AND THAT THE ATTACHED PHOTOGRAPH IS A TRUE LIKENESS OF MYSELF. I HAVE READ THE QUESTIONS IN THIS APPLICATION AND ANSWERED THEM TO THE BEST OF MY ABILITY AND KNOWLEDGE. FURTHER, SHOULD I FURNISH ANY FALSE INFORMATION ON THIS APPLICATION I HEREBY AGREE THAT SUCH ACT SHALL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION OR IMMEDIATE REVOCATION OF MY LIMITED TEMPORARY LICENSE.

Cheryl Ann Gibson
SIGNED

SUBSCRIBE AND SWORN TO BEFORE ME THIS 13 DAY OF May, 1985

COUNTY Chittenden STATE Vermont

NOTARY PUBLIC Enid H Beel
SIGNED

Mail completed form to:

Board of Medical Practice
Licensing & Registration
Pavilion Building
Montpelier, VT 05602

Telephone: (802) 828-2673

NATIONAL BOARD OF MEDICAL EXAMINERS®

3930 CHESTNUT STREET PHILADELPHIA, PA. 19104

REPORT OF SCORES PART I

NBME NUMBER	TEST DATE	SCHOOL CODE	SCHOOL GRAD
308479	09-83	179	85

	ANAT	PHYS	BIOCH	PATH	MICRO	PHARM	BEHSCI	TOTAL SCORE	PASS FAIL
STANDARD SCORE	395	365	520	505	450	525	480	455	P
PERCENTILE CRITERION	14	8	57	51	30	58	41	31	
PERCENTILE REFERENCE	16	9	49	51	21	49	33	26	

GIBSON CHERYL A

[redacted]

NB308479
8

SCORE INTERPRETATION IS PROVIDED ON THE ENCLOSED SHEET

NATIONAL BOARD OF MEDICAL EXAMINERS®

3930 CHESTNUT STREET PHILADELPHIA, PA. 19104

REPORT OF SCORES PART II

NBME NUMBER	TEST DATE	SCHOOL CODE	SCHOOL GRAD
308479	04-84	179	85

	MED.	SURG.	OB/GYN	PM/PH	PED.	PSYCH.	TOTAL SCORE	PASS FAIL
STANDARD SCORE	405	440	680	480	445	470	485	P
PERCENTILE CRITERION	16	26	97	41	28	37	43	
PERCENTILE REFERENCE	19	28	98	41	32	31	45	

GIBSON CHERYL A

[redacted]

NB308479
8

SCORE INTERPRETATION IS PROVIDED ON THE ENCLOSED SHEET

SUPERVISORY AUTHORIZATION

This section must be completed by the physician who will be supervising your work while in Vermont. This licensed physician will be responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee. Termination of appointment as interne, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. Such limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or upon ten-days written notice of the licensed physician.

I certify that the said Dr. Cheryl A. Gibson is engaged as an interne, resident, fellow or medical officer for the Medical Center Hosp of Vermont Hospital for the period 6/23/85 to 6/30/86.

I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary licensee.

John D Lowe M.D.
Supervising Physician

Vermont License # 3540

Seal of Hospital (NOTE: If hospital has no seal the signature must be acknowledged before a Notary Public)

State of Vermont

County of Chittenden

In _____ on the _____ day of _____ 19___, before me personally appeared _____ M.D. to me known and known by me to be the party executing the foregoing instrument, and he acknowledged said instrument, by him executed, to be his free act and deed.

(SEAL)

_____
Notary Public

My commission expires on _____.

CERTIFICATE OF GRADUATION

Must be Completed For All Applicants

To whom it may concern:

This is to certify that Cheryl Ann Gibson

attended University of Vermont College of Medicine

from September 1981 until May 1985

The degree Doctor of Medicine was conferred on May 18, 1985

(President, Secretary or Dean)

David M. Tormey, M.D.

Associate Dean for Admissions and Student Affairs

(Title)

(SEAL)

May 20, 1985

Date

Please forward completed form to:

Board of Medical Practice
Licensing & Registration
Pavilion Building
Montpelier, VT 05602

Telephone: (802) 828-2673

MEDICAL BOARD PHYSICIAN STATUS SHEET

NAME: Cheryl Ann Gibson, M.D.

ADDRESS: [redacted]

Application Received: ✓ Fee Received: _____

X Birth Certificate, Notorized

X Certified Copy of Medical School Diploma from University of Vermont

X Certificate of Medical Education, Section II

NA ECFMG Certificate, Certified

NA License Verification (Section III) from _____

NA License Verification (Section III) from _____

NA License Verification (Section III) from _____

X FLEX Score NA National Board Score 81,2 (From FLEX or National Board)

NA Specialty Board Certificate, Certified from _____

X Post Graduate Certificate from Medical Center Hospital of Vermont

X Reference Letter from Daniel H. Riddick, M.D., Ph.D.

X Reference Letter from Mildred A. Reardon, M.D.

X Reference Letter from Susan F. Smith

___ AMA Profile Sheet Requested _____ Received ✓

Interviewer: _____ Date Sent: _____

COMMENTS: _____

_____

_____

State of Vermont
Board of Medical Practice
Redstone Building, 26 Terrace Street
Mail: Pavilion Office Building
Montpelier, Vermont 05602-2198
(802) 828-2673

Toll Free 1-800-642-5155

James H. Douglas
Secretary of State

Paul S. Gillies
Deputy Secretary of State

STATE OF VERMONT

BOARD OF MEDICAL PRACTICE

June 19, 1989

Cheryl Gibson, M.D.
[redacted]

Dear Doctor Gibson:

Enclosed please a renewal form for your to fill out for renewal of your licensure in Vermont. Please make sure that you sign the back of the renewal form, answell of the questions on the front, and include a check for $106.00 ($96.00 renewal fee and $10.00 late fee).

If I do not receive your renewal and check within 10 working days from the date of this letter, your license will be considered expired pursuant to Board Rules §2.3.1 and a lapsed license application will have to be completed by you.

If you have any questions, please feel free to contact me.

Sincerely,

Debbie Morehouse
Staff Assistant
VT Board of Medical Practice

/dm

Enclosure

LICENSING & REGISTRATION DIVISION
PAVILION OFFICE BUILDING
MONTPELIER, VERMONT 05602

PRESORTED FIRST CLASS

MONTPELIER VERMONT

FIRST CLASS
U.S. POSTAGE
PAID
PERMIT NO.
367

[redacted]

GIBSON CHERYL A, M.D.

[redacted]

ATTEMPTED NOT KNOWN
Initials RT. #

EXPIRED.

CARBONIZED FORM - DO NOT WRITE ON THIS COVER SHEET

[redacted]

RENEWAL APPLICATION

I hereby apply for the renewal of my License AS

A Physician

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

under the provisions of Title 26, Chapter 23 V.S.A. LICENSE NUMBER 42-0007465

I enclose the correct fee as follows: $ 96.00

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

GIBSON CHERYL A, M.D.

[redacted]

FOLD HERE →

READ REVERSE FIRST

SPECIAL INSTRUCTIONS

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

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

FROM: _____

_____

_____

PLACE FIRST CLASS POSTAGE HERE

SECRETARY OF STATE
LICENSING & REGISTRATION DIVISION
PAVILION OFFICE BUILDING
MONTPELIER, VERMONT 05602

RENEWAL

- ☒ Have you CHECKED application for CORRECT spelling of name and proper address?
- ☒ DID YOU sign and date application?
- ☒ Have you enclosed the CORRECT fee in a check or money order (no cash) payable to SECRETARY OF STATE?

BE SURE TO USE THIS ENVELOPE FOR YOUR RETURN.
MOISTEN, FOLD OVER AND SEAL

RENEWAL APPLICATION

I hereby apply for the renewal of my License as a **Physician** for the period from 02/01/1989 to 11/30/90, under the provisions of Title 26, Chapter 23 VSA. **Renewal Fee** ~~$96.00~~ $101.00 **License #** 42- 0007465

YOU MUST SIGN THE REVERSE SIDE OR YOUR LICENSE WILL NOT BE RENEWED

Gibson, Cheryl A.
[redacted]

SECRETARY OF STATE
RECEIVED
JUN 26 1989
LICENSING AND REGISTRATION

SPECIAL INSTRUCTIONS

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

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

A new law provides that a professional license may not be renewed unless the licensee certifies that he or she is in good standing with the Department of Taxes. Good Standing means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with the payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship (32 V.S.A. § 3113).

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

Remember, if you don't sign this certificate, your license will not be renewed.

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

Date 6/20/89 Signature _____

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

STATE OF VERMONT
RENEWAL APPLICATION

I hereby apply for the renewal of my: Physician License

CHERYL A GIBSON MD

[redacted]

Current Expiration	Renewal Period Covering	Renewal Fee	Lic/Cert #
11/30/90	12/01/90 - 11/30/92	150.00	42-0007465

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

INFORMATION NEEDED

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

Had any illness or conditions which impaired your ability to function as a physician? [redacted]
Had any convictions other than for minor traffic violations? YES/[redacted]
Had an addiction to or been treated for abuse of drugs or alcohol? [redacted]
Had any jurisdiction deny or take action against your license? YES/NO
Had any final liability judgments or settlements against you? YES/NO
Had any hospital privileges denied, conditioned or revoked? YES/NO
Recently started practicing in Vermont? YES/NO 9/89
List all hospitals you currently hold hospital privileges or have held in the past two years: (give dates) Medical Center Hospital of Vermont 9/89 - Present

ADDITIONAL QUALIFICATIONS FOR RENEWAL

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

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

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

STATEMENT OF APPLICANT

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

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

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

Date 10/22/90 Signature _____

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

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

FOLD HERE

RENEWAL APPLICATION

I hereby apply for the renewal of my License AS
A Physician
for the period from 02/01/1987 to 01/31/1989
under the provisions of Title 26 Chapter 23 V.S.A. LICENSE NUMBER 42-0007465
I enclose the correct fee as follows: $ 100.00

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

GIBSON CHERYL A, M.D.

[redacted]

FOLD HERE

READ REVERSE FIRST

SPECIAL INSTRUCTIONS

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

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

A new law provides that a professional license may not be renewed unless the licensee certifies that he or she is in good standing with the Department of Taxes. Good standing means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with the payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship (32 V.S.A. § 3113).

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

Remember, if you don't sign this certificate, your license will not be renewed.

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

DATE 1/15/87 SIGNATURE [signature]

INSTRUCTIONS FOR USING THIS FORM

1. Check for correct spelling of name and proper address. Print changes in adjoining space.
2. Sign and date the application.
3. Enclose the correct fee in a check or money order (no cash) payable to Secretary of State.
4. Return application and fee in the pre-addressed return envelope provided.
5. Your new license will not be issued until just before the new license period starts. There's no need to check with us before then to see if we got your application. In fact, it would slow things down.
6. Write the Licensing and Registration Division immediately whenever you have a change of address or name.

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

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

42-0007465 A

Cheryl A. Gibson MD

[redacted]

Rec'd 10-14-82

****

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: Cheryl A. Gibson MD 2. Vermont License Number: 42- # 7465

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

4. Home Address: [redacted]

City, State, Zip Code [redacted]

5. Office Address: 23 Mansfield Ave

City, State, Zip Code: Burlington Vermont 05401

6. Daytime Telephone Number: Area Code: [redacted]

7. Date of Birth: Month: [redacted]

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

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

11. Undergraduate Degree - Circle: B.A. (B.S.) A.B. Other: ___ Year of Graduation: 1977

Degree Granting Institution: UVM Location: Burlington VT
First Institution (If transfer): ___ Location: ___

12. Medical Degree - Circle: (M.D.) Other: ___ Year of Graduation: 1985

Degree Granting Medical School: UVM Location: Burlington VT

First Medical School (If transfer): ___ Location: ___

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

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

Name(s) and Location(s) of Hospital(s): Medical Center Hosp of Vermont
Fanny Allen Hospital

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

15. Other states where you now hold an active license to practice: New Hampshire, Maine

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

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

Specialty(ies) & Subspecialty(ies)	American Specialty Board Certified (Yes or No)	
(a) OB-Gyn	X Yes ____ No	Year Certified/Recertified: 12/91
(b)	____ Yes ____ No	Year Certified/Recertified: ____/____
(c)	____ Yes ____ No	Year Certified/Recertified: ____/____

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

	Institution	City	State	Degree	Year
(a)					
(b)					

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

	Institution	City	State	Specialty	Year Completed
(a)	MCHV	Burlington	VT	OB-Gyn	1981
(b)					
(c)					

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

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

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

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

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

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

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

SECTION II CONTINUED

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

7. 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)? [redacted]

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

9. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art? ___ YES X NO

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

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

12. Have you ever withdrawn an application for a medical license or been denied a medical license for any reason? ___ YES X NO

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

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

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

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

SECTION III - TO BE COMPLETED ONLY BY PHYSICIANS PRACTICING IN VERMONT

1. Current Status (please check one): X Active ___ Retired* ___ Other (please explain) _____
***Note: If you are retired or are not practicing in Vermont, you need not complete SECTION III; however you must complete SECTION IV.**

2. Postgraduate training in Vermont:
Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? ___ Yes X No
If you are in a Vermont program, are you a ___ Resident ___Clinical Fellow ___ Research Fellow?
How many hours per typical week do you spend in this Vermont postgraduate training program? _____hrs./wk. in Vermont.

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
(Month/Year) 9 / 89

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
(Month/Year) 9 / 89

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

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

SECTION III CONTINUED

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

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

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

6. Practice Site Number One
Street Address: 23 Mansfield Ave
Town: Burlington Zip: 05401
Please complete **one full line for each specialty** (example: pediatrics) that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
OB-Gyn	60	12	No	Yes	25%	Yes	10%	Yes

Check the financial organization which best describes this site: ____ For-profit X Nonprofit
If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty:
____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care X Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? Have Stopped doing OB as of 4/92
(For example, a physician specializing in family practice who performs deliveries would check "Obstetrics".)

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

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

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

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

SECTION III CONTINUED

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

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

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

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

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

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

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

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

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

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

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

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT

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

OR

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

APPLICANT'S STATEMENT REGARDING TAXES

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

OR

____ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application 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 Numbe [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: 9/30/92 **Signature:** [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 license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of $205.* in check or money order payable to the Vermont Board of Medical Practice.
(Medical Board Renewal Fee: $200. + Office of Professional Regulation (OPR) Fee: $5.00 = $205. OPR's $5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

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

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

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

Your Name: Cheryl Gibson **Vermont License Number:** 7465
only section K applies

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insurer: _____

Claimant Name: _____

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

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

_____

Incident Location (circle one):

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

Section A continued on next page

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

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

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

Name: _____

Firm: _____

Address: _____

City, State, Zip: _____

Telephone Number: ( ) _____

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

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

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

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

_____

_____

_____

_____

Table I for Section A on the next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE THREE OF SIX
TABLE I - BASIS CODES - ALLEGATIONS ONLY

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: CRIMINAL INVESTIGATION - PROCEEDING (QUESTIONS 3 AND 4) - ATTACH DOCUMENTS

Court: _____ Charge: _____ Date: _____

Description: _____

_____

_____

_____

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

SECTION C: DISCIPLINARY CHARGES OR ACTION (QUESTION 6) - ATTACH DOCUMENTS

Name of Organization Involved: _____ Date: _____

Duration: _____

Action Taken (circle all that apply):

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

Circumstances: _____

_____

_____

_____

SECTION D: PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES (QUESTION 10) - ATTACH DOCUMENTS

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

_____

_____

_____

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

SECTION E: WITHDRAWAL OR DENIAL OF LICENSE (QUESTION 12) - ATTACH DOCUMENTS

State: _____ Year: _____

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

_____

_____

SECTION F: INVESTIGATION BY ANY OTHER LICENSING BOARD (QUESTION 15) - ATTACH DOCUMENTS

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

_____

_____

SECTION G: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED (QUESTION 16) - ATTACH DOCUMENTS

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

_____

SECTION H: TREATMENT FOR EMOTIONAL DISTURBANCE OR MENTAL ILLNESS, ORGANIC ILLNESS, ALCOHOL OR DRUG DEPENDENCY (QUESTIONS 1, 2 AND 5)

Treating Organization: _____

Address: _____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

_____

_____

_____

Dates of Illness/Dependency: _____ to _____

Dates of Treatment: _____ to _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE SIX OF SIX

SECTION I: AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 8) - ATTACH DOCUMENTS

Institution Involved: _____

Date: _____

Circumstances: _____

_____

_____

SECTION J: VOLUNTARILY SURRENDERED OR RESIGNED A LICENSE TO PRACTICE MEDICINE OR ANY HEALING ART (QUESTION 9) - ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances: _____

_____

_____

SECTION K: DENIAL OF RIGHT TO PARTICIPATE OR ENROLL - THIRD PARTY PAYER (QUESTION 11) ATTACH DOCUMENTS

Third Party Payer: CHP Year: 1992

Circumstances: Tried to enroll as CHP provider and was told (over the phone only) that they did not want to be affiliated with Planned Parenthood (my employer)

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

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____

_____

SECTION M: SEVERITY LEVEL III NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 14) ATTACH DOCUMENTS

PRO: _____ Year: _____

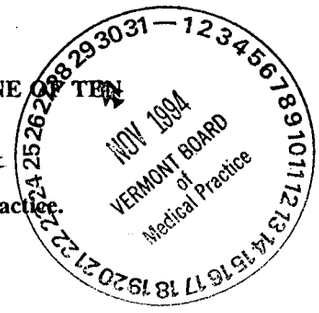
Location of PRO: _____

Circumstances: _____

_____

_____

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



I hereby apply for the renewal of my **LICENSE AS A PHYSICIAN** for the period from **12/01/94 to 11/30/96. TWO YEAR RENEWAL FEE: $205.00.** already sent *
Enclose a check in the amount of $205.00 made payable to the Vermont Board of Medical Practice.

already sent
This is a corrected page 11/28/94 CAG MD

****

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

-Thank you for your cooperation.

SECTION I

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

1. Name: Cheryl A. Gibson MD
2. Vermont License Number: 7465
3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal:

_____

4. Home Address: not available

City, State, Zip Code:

5. Office Address: 23 Mansfield Ave
Burlington VT 05401

City, State, Zip Code:

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

6. Daytime Telephone Number: [redacted]
7. Date of Birth: [redacted]
8. Place of Birth: [redacted]
9. Sex (M/F): Female

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

SECTION I CONTINUED

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

11. Undergraduate Degree: (B.A., B.S., etc.): BS Year of Graduation: 1977

Major Course of Study: Professional Nursing

Degree Granting Institution: Univ. of Vermont

Location: Burlington Vermont

First Institution (If transfer):_____

Location:_____

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1985

Degree Granting Medical School: University of Vermont College of Medicine

Location: Burlington Vermont

First Medical School (If transfer):_____

Location:_____

13. Do you have hospital privileges **in Vermont**? X Yes ___No
Name(s) and Location(s) of Hospital(s): Medical Center Hospital of Vermont
Fanny Allen Hospital

14. Did you practice in Vermont during the past 12 months? X Yes ___No

15. Other states where you hold an active license to practice: Maine New Hampshire

16. States where you previously were licensed to practice: none

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

	Specialty Code(s) (See the list of specialty codes.)	**American Board of Medical Specialties Certified** (Yes or No)	**Year Certified/Recertified**
(a)	___ ___ ___ ___	_____	____/____
(b)	___ ___ ___ ___	_____	____/____
(c)	___ ___ ___ ___	_____	____/____

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

SECTION I CONTINUED

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

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

SECTION I CONTINUED

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

	Institution	City	State	Country
(a)	Medical Center Hosp of VT UVM College of Medicine	Burlington	VT	USA

Specialty Code (See attached list of specialty codes)	Year Completed
1101	1989

	Institution	City	State	Country
(b)				

Specialty Code (See attached list of specialty codes)	Year Completed

	Institution	City	State	Country
(a)				

Specialty Code (See attached list of specialty codes)	Year Completed

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

Name of P.A.	Check if: Primary	and/or Secondary
Judith Sullivan PA		X
Hanna Hauser PA		X
Cate Nicholas PA		X
Amy Boardman PA		X

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

SECTION I CONTINUED

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

all nurse practitioners working for Planned Parenthood of Northern New England

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

SECTION I CONTINUED

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

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

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

During the past two years:

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

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

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

4. Have you been dependent upon alcohol or drugs?

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

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

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

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

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

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

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

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

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

SECTION II CONTINUED

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

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

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

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

SECTION III

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

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

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

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

OR

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

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

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

OR

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

(3) SOCIAL SECURITY NUMBER: [redacted]

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

(4) STATEMENT OF APPLICANT

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

Date: 10/17/94 **Signature:** _____

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

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

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

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

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

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

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

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

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VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

To be completed only by physicians practicing in Vermont.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

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

1. Current Status (please check one): X Active ___Retired* ___Other (please explain) _____

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? ___Yes X No
   (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow?
   (c) How many hours per typical week do you spend in this Vermont postgraduate training program?
   _____hrs./wk. in Vermont.
   (d) What is the medical school that you are affiliated with for this training?
   _____University of Vermont _____Dartmouth _____Other (Please specify)_____

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
   (Month/Year) 9 / 89

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
   (Month/Year) 9 / 89

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

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

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

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

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

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

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

42-7465 **Gibson, Cheryl A.**

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): Womens Choice Gyn Associates / Planned Parenthood of Northern New England
Street Address: 23 Mansfield Ave
Town: Burlington VT Zip Code: 05401

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

Is your **personal** income from this practice site based on (check as many as apply):
X 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 owned/operated Practice

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
1101	50	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	
X	General adult medical care	5
	General geriatric medical care	
X	General gynecological medical care	45
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

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

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

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

Name of Practice(s): _____
Street Address: _____
Town: _____ Zip Code: _____

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

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

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

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

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

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

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

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

Medilert-IRIS™
Division of The Castlemark Corp.
P.O. Box 14050
Scottsdale, AZ 85267-4050

PH. 800-846-1351
FAX 800-765-4814

VT-250

August 31, 1995

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

ATTN: License Verification

RE: ***Gibson, Cheryl A., MD***
LICENSE #: 7465

Dear Sir/Madam:

The above named individual has submitted an application to MEDILERT-IRIS for processing. As part of the credentialing process, we are requesting verification of this individual's claimed licensing. We have enclosed appropriate data regarding this individual as well as a photocopy of a signed release.

A self-addressed stamped envelope has been enclosed for your convenience.

Sincerely,

Jennifer Douglas

Jennifer Douglas, VT-250
Administrative Assistant

VERIFICATION:

1. Provider's License Number: 42-0007465
2. Issuance date: 09/10/86
3. Expiration Date: 11/30/96
4. Is there a record of any license suspension, restriction or revocation regarding this provider? Yes_____ No X

If yes, please explain:_____

Janice E. Lifield Staff Assistant 9/18/96
Signature/Title Date

We have examined the records of the appropriate Court offices for the above Counties. To the best of our knowledge the information on this page is accurate and complete, but no liability is assumed for or by reason for any errors or omissions.

I, Cheryl A Gibson MD, do hereby grant to Planned Parenthood Federation of America, Inc., and its affiliates, and/or their agents, permission to gain access to, inspect and duplicate any and all information, records, summaries or records and statistical reports (including physician utilization profiles pertinent to my provision of medical services and my medical professional qualifications) currently on file at any and all acute care facilities, skilled nursing facilities, outpatient centers and any other institutional settings with which I am or have been affiliated; any local county, state and federal medical trade association, accrediting organization, medical society or governmental entity.

I hereby release Planned Parenthood Federation of America, Inc., and its affiliates, employees, and/or its authorized agents, from any and all liability or expense which is incurred by Planned Parenthood Federation of America, Inc., its affiliates, employees or its authorized agents, due to the release of any of the information described in this Provider Application to any purchaser of health care services or to any representatives of local, state and federal governmental agencies.

I agree to immediately notify the Planned Parenthood affiliate with whom I am associated, upon termination, suspension or denial of my malpractice insurance. I also agree to immediately notify the Planned Parenthood affiliate with whom I am associated upon termination, suspension or revocation of my staff privileges at any hospital or health care facility.

Signature of Clinician: [signature] Date: 6/15/95

This authorization is valid for 24 months from the date shown above.
A photocopy shall be considered as valid as the original.

042-0007465

Cheryl A. Gibson MD
23 Mansfield Avenue
Burlington, VT 05401

Vermont Department of Health
Board of Medical Practice

Agency of Human Services

RECEIVED
NOV 18 2002
VERMONT BOARD OF MEDICAL PRACTICE

November 1, 2002

Dear Physician:

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

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

enclosed

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

Thank you.

Sincerely,

Medical Practice Board
(802) 657-4220

Enclosures

108 Cherry Street • PO Box 70 • Burlington, VT 05402-0070 **TEL** 802- 657-4220 or 800-745-7371
FAX 802- 657-4227

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.

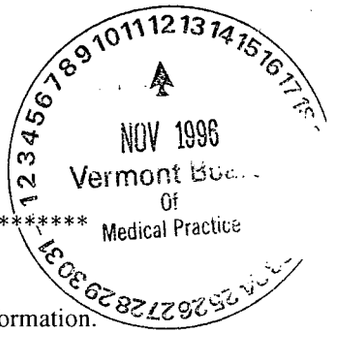
Signature of Applicant _____ Date 11/18/02

42-7465 GIBSON, CHERYL A.

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

Pd

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



CHERYL A. GIBSON
23 MANSFIELD AVE
BURLINGTON, VT 05401

****

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

SECTION I

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

1. Name: CHERYL A GIBSON

2. Vermont License Number: 42-7465

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

4. Home Address: _____

City, State, Zip Code: , VT _____

5. Office Address: 23 MANSFIELD AVE _____

City, State, Zip Code: BURLINGTON, VT 05401 _____

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

6. Daytime Telephone Number: [redacted] _____

7. Date of Birth: [redacted] _____

8. Sex (M/F): F

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

42-7465 GIBSON, CHERYL A:

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

SECTION I CONTINUED

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

11. Undergraduate Degree: (B.A., B.S., etc.): BS Year of Graduation: 1977

Major Course of Study: NURSING

Degree Granting Institution: UNIV OF VERMONT

Location: BURLINGTON, VT USA

First Institution (If transfer): _____

Location: _____

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1985

Degree Granting Medical School: Univ. of Vermont

Location: BURLINGTON, VT USA

First Medical School (If transfer): _____

Location: _____

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

(a) ~~FANNY ALLEN HO~~SPITAL > now Fletcher Allen Health Care

(b) ~~MEDICAL CENTER HOSPITAL OF VERMONT~~

(c) _____

(d) _____

(e) _____

14. Other states where you hold an active license to practice: Maine, New Hampshire.

15. States where you were previously licensed to practice: N/A

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

SECTION I CONTINUED

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

	Specialty Code	Specialty Name	Board Certified ([Y]es/[N]o)	Year Certified/Recertified
(a)	1 1 0 1	OBSTETRICS & GYNECOLOGY	Y	1991 /
(b)				/
(c)				/

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

	Residency Institution #1	Residency Institution #2	Residency Institution #3
Institution Name	MCHV		
City	BURLINGTON		
State	VT		
Country	USA		
Specialty Code (See list)	1 1 0 1		
Specialty Name	OBSTETRICS & GYNECOLOGY		
Year Residency Completed	1989		

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

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

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

During the past two years:

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

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

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

4 Have you been dependent upon alcohol or drugs?

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

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

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

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

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

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

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

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

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

SECTION II CONTINUED

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

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

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

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

SECTION III

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

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

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

(continued on page 8)

YOU MUST COMPLETE OTHER SIDE

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

SECTION III CONTINUED

Regarding Unemployment Compensation Contributions

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

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

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

or

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

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

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

5. **STATEMENT OF APPLICANT**

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

Date: 10/28/96 Signature: [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

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

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

SECTION IV

42-7465 GIBSON, CHERYL A.

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:
   - X Active in clinical practice in Vermont
   - X Active in clinical practice outside Vermont
   - X Administration
   - X Teaching
   - __ Research
   - __ Retired
   - __ Other

   (b) How many hours per week do you spend on administration, teaching and research? 5 hours

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?
   __Yes X 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) 09/1989

4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?
   (Month/Year) 09/1989

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

SECTION IV CONTINUED

Instructions for completing this portion:

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

6(a). WORK SITE: NUMBER ONE

Town: BURLINGTON County: CHITTENDEN

(*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
X 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	OBSTETRICS & GYNECOLOGY	50
Secondary Specialty at this Site			
Other Specialty at this Site			

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

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

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

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

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes X 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(b). WORK SITE: NUMBER TWO

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

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

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

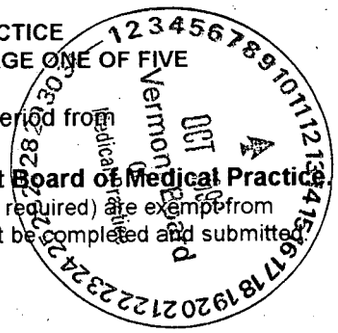
Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

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

Pd

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



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

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

Physicians 80 years of age or older or on full time active military duty (verification required) are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.

LATE FEE: Late applications are assessed a $25 late fee.

042-0007465

Cheryl A. Gibson MD
23 Mansfield Avenue
Burlington, VT 05401

****

Important:

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

SECTION I

Name: Gibson (Last) Cheryl (First) A. (Middle) _____ (Former)

Vermont License Number: 42 0007465

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

* Mailing Address: 23 Mansfield Ave (Street)

Burlington (City) VT (State) 05401 (Zip Code) 802-8639001 (Phone)

Office Address: Same (Street)

_____ (City) _____ (State) _____ (Zip Code) _____ (Phone)

Home Address: _____

City, State, Zip Code: _____

Note: Circle your preferred mailing address. Please note that this address will be public and listed on the Board's website.

Daytime Telephone Number: Area Code: [redacted]

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

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

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

SPECIALTY

Specialty: Obstetrics + Gynecology

Subspecialty: _____

American Specialty Board Certified? X Yes ____ No

Specialty?: OB/Gyn Year Certified?: 1991

If applicable, year recertified? 2001

Subspecialty Certificate?: _____ Year Certified? _____

If applicable, year recertified? _____

PRACTICE

Do you have hospital privileges? X Yes ____ No

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

Name	Address	From/To	Specialty/Subspecialty
Fletcher Allen Health Care	Burl VT	1989 → present	OB/Gyn

OTHER LICENSES

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

State	License Number	Date Issued	Status (Active or Inactive)
New Hampshire	7539	4/1/87	Active
Maine	013193	11/20/91	Active

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

SECTION II

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

During the past two years:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If "yes," [redacted]

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

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

STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

Applicant's Statement Regarding Child Support

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

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

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

or

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

Applicant's Statement Regarding Taxes

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

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

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

or

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

Applicant's Statement Regarding Unemployment Compensation Contributions

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

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

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

or

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

Social Security [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, is authorized 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 10/4/98

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

RECEIVED NOV 1 2000 VERMONT BOARD OF MEDICAL PRACTICE

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

042-0007465

Cheryl A. Gibson MD
23 Mansfield Avenue
Burlington, VT 05401

****

IMPORTANT:

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

SECTION I

Name: Gibson (Last) Cheryl (First) A. (Middle) _____ (Former)

Vermont license number: 042000 7465 Other name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal _____

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

MAILING ADDRESS: 23 Mansfud Ave (Street)

Burlington (City) VT. (State) 05401 (Zip Code) 802-863900 1 (Telephone)

OFFICE ADDRESS: 23 Mansfud Ave (Street)

Burlington (City) VT (State) 05401 (Zip Code) 802-863900 1 (Telephone)

HOME ADDRESS: 23 Mansfud Ave (Street)

Burlington (City) VT (State) 05401 (Zip Code) 802 863900 1 (Telephone)

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

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

SPECIALTY

Specialty: OB/Gyn

Subspecialty: _____

American Specialty Board Certified: ✓ Yes ____ No

Specialty: OB/Gyn Year Certified: 1991

If applicable, year recertified: _____

PRACTICE

Do you have hospital privileges? ✓ Yes ____ No

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

Name	Address	Dates/From-To	Specialty/Subspecialty
Fletcher Allen Health Care		6/89 - present	OB/Gyn.

LICENSE IN OTHER JURISDICTIONS

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

State	License Number	Date Issued	Status (Active, Inactive, Other)
New Hampshire	7539	4/1/87	Active
Maine	013193	11/20/91	Active

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

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

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

DURING THE PAST TWO YEARS:

1. Have you ever applied for and been denied a license to practice medicine or any healing art? ___ Yes ✓ No
2. Have you ever withdrawn an application for a license to practice medicine or any healing art? ___ Yes ✓ No
3. Have you ever voluntarily surrendered or resigned a license to practice medicine 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 medical 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, suspended, 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 patient) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___ Yes ✓ No
12. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? [redacted]
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 by or surrendered to 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: 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]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. If yes to 22, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If yes, explain on Form A.

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

[redacted]

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

SECTION IV

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

PAGE FIVE OF FIVE

You must answer questions 1, 2, and 3.

Regarding Child Support

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

1. **You 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 [signature] Date 10/23/10

1428

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

2002 PHYSICIAN'S LICENSE RENEWAL APPLICATION

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

Instructions

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

Part I - Identity Questions

Vermont Physician's License Number: 042-0007465

RECEIVED
OCT 28 2002
VERMONT BOARD OF MEDICAL PRACTICE

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

First name: Cheryl

Middle name: A

Last name: Gibson

Extension:

2. Have you ever legally changed your name? ☐ Yes ☒ No

Former name, or any other name under which you were licensed in Vermont or elsewhere in the past two years: _____

3. Your date of birth: M M D D Y Y Y Y [redacted]

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

Care of:

Street: 23 Mansfield Ave.

Town/City: Burlington

State: VT

Zip Code: 05401-

5. Your electronic addresses:

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

Work telephone: 802 - 863 - 9001 x

E-mail (optional):

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

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

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

If yes, complete the section below:

State	License Number	Date Issued (M M D D Y Y Y Y)	Status (Active, inactive, other)
NH	7539	04 01 1987	Active
ME	013193	11 20 1991	Active

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

Part II - Licensure and Practice Questions

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

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

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

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

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

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

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

Part III - Confidential Section

Part III is exempt from public disclosure

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

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

[redacted]

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

[redacted]

MEDICAL QUESTIONS

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

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

[redacted]

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

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

[redacted]

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

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

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

Part IV - Statutory Profile Questions

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

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

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

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

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

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

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

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

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

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

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

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

Date M M D D Y Y Y Y	Final Disposition (Summary)
[redacted]	

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

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

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

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

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

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

A. **Revocation/Involuntary Restrictions**

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

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

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

B. Other Restrictions

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

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

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

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

A. Judgments

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

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

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

B. Settlements

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

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

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

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

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

School	City	State	Year of Graduation
Univ. of Vermont	Burlington	VT	1985

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

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

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

School/Institution	Specialty	City	State	Year of Graduation
Univ. of Vermont/MCHV	OB/gyn	Burlington	VT	1989

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

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

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1101		☑ yes ☐ no	Am. Board OB/gyn	1991	2001
		☐ yes ☐ no			
		☐ yes ☐ no			

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

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

M	M	Y	Y	Y	Y
0	6	1	9	8	9

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

List all hospitals where you currently have hospital staff privileges:

Name	City	State		Year Started			
Fletcher Allen Health Care	Burlington	V	T	1	9	8	9

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

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

A. Appointments

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

School	City	State	Nature of Appointment	From (year)	To (year)
Univ. of Vermont College of Medicine	Burlington	V T	Clinical Associate Professor	1989	present

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

B. Teaching

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

School/Institution	City	State	Nature of Teaching	From (year)	To (year)
Univ. of Vermont College of Medicine	Burlington	V T	Medical Students + Residents	1989	present

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

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

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

Title	Publication	Year
attached with CV		

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

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

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

Activities or Awards
Medical Director - Planned Parenthood of Northern New England

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

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

What is the location of your primary practice setting?

Town or City: Burlington

State: VT

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

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

☐ **Yes** ☒ **No**

If yes, please describe here the translating services available:

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

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

A. Medicaid participation

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

B. New Medicaid Patients

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

Part V - Clinical Practice Questions

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

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

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

BEFORE YOU CONTINUE:

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

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

M M	Y Y Y Y
0 6	1 9 8 9

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

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

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

Site 1: Burlington

Site 2: Barre

Site 3:

Site 4:

Question	Site 1	Site 2	Site 3	Site 4
B. Number of weeks per year that you spend providing direct patient care at this site: (Full-time is considered to be 48 weeks / year)	40	04		

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

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

	Site 1	Site 2	Site 3	Site 4
Specialty Code	1101	1101		
(Specialty name, if code unknown)				
Hours per week	10	02		
Secondary Specialty, if any				
Hours per week in secondary specialty				
Tertiary Specialty, if any				
Hours per week in tertiary specialty				

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

Part VI - Signature

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

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

Date: 10/11/02 _____

_____
Applicant's Signature

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

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

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

_____

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

State_____ Year_____

Circumstances_____

_____

Disciplinary charges or action (Question 12) - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

Denial of examination privileges (Question 13) - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

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

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

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

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

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

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

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

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

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

Treating organization _____

Address _____Telephone _____

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

_____

_____

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

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

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101	Allergy and Immunology
0102	Clinical & Laboratory Immunology
0201	Anesthesiology
0202	Critical Care Medicine
0203	Pain Management
0301	Colon & Rectal Surgery
0401	Dermatology
0402	Dermatopathology
0403	Clinical & Laboratory Dermatology
0404	Dermatological Immunology
0501	Emergency Medicine
0502	Medical Toxicology
0503	Pediatric Emergency Medicine
0504	Sports Medicine
0601	**Family Practice**
0602	**Geriatric Medicine**
0603	Sports Medicine
0701	**Internal Medicine**
0702	**Adolescent Medicine**
0703	Cardiac Electrophysiology
0704	Cardiovascular Disease
0705	Critical Care Medicine
0706	Clinical & Lab Immunology
0707	Endocrinology Diabetes & Metabolism
0708	Gastroenterology
0709	**Geriatric Medicine**
0710	Hematology
0711	Infectious Disease
0712	Medical Oncology
0713	Nephrology
0714	Pulmonary Disease
0715	Rheumatology
0716	Sports Medicine
0801	Medical Genetics
0802	Clinical Biochemical Genetics
0803	Clinical Biochemical/Molecular Genetics
0804	Clinical Cytogenetics
0805	Clinical Genetics (Md)
0806	Clinical Molecular Genetics
0901	Neurological Surgery
0902	Critical Care Medicine
1001	Nuclear Medicine
1101	**Obstetrics & Gynecology**
1102	Critical Care Medicine
1103	Gynecologic Oncology
1104	Maternal & Fetal Medicine
1105	Reproductive Endocrinology
1201	Ophthalmology
1301	Orthopaedic Surgery
1302	Hand Surgery
1401	Otolaryngology
1402	Otology/Neurotology
1403	Pediatric Otolaryngology
1501	Anatomic & Clinical Pathology
1502	Anatomic Pathology
1503	Clinical Pathology
1504	Blood Banking/Transfusion Medicine
1505	Chemical Pathology
1506	Cytopathology
1507	Dermatopathology
1508	Forensic Pathology
1509	Hematology
1510	Immunopathology
1511	Medical Microbiology
1512	Neuropathology
1513	Pediatric Pathology
1601	**Pediatrics**
1602	**Adolescent Medicine**
1603	Clinical & Laboratory Immunology
1604	Medical Toxicology
1605	Neonatal-Perinatal Medicine
1606	Pediatric Cardiology
1607	Pediatric Critical Care Medicine
1608	Pediatric Emergency Medicine
1609	Pediatric Endocrinology
1610	Pediatric Gastroenterology
1611	Pediatric Hematology-Oncology
1612	Pediatric Infectious Disease
1613	Pediatric Nephrology
1614	Pediatric Pulmonology
1615	Pediatric Rheumatology
1616	Pediatric Sports Medicine
1617	Children with Special Health Needs
1701	Physical Medicine & Rehabilitation
1801	Plastic Surgery
1802	Hand Surgery
1901	Preventive Medicine
1902	Aerospace Medicine
1903	Occupational Medicine
1904	Public Health & General Preventive
1905	Medical Toxicology
1906	Underseas Medicine
	Psychiatry & Neurology (Board Name - Not A Specialty)
2001	Psychiatry
2002	Neurology
2003	Neurology With Special Qualifications In Child Neurology
2004	Addiction Psychiatry
2005	Child & Adolescent Psychiatry
2006	Forensic Psychiatry
2007	Geriatric Psychiatry
2008	Clinical Neurophysiology
2101	Radiology
2102	Diagnostic Radiology
2103	Radiation Oncology
2104	Radiological Physics
2105	Nuclear Radiology
2106	Pediatric Radiology
2107	Vascular & Interventional Radiology
2201	Surgery
2202	Surgery Of The Hand
2203	Pediatric Surgery
2204	Surgical Critical Care
2205	General Vascular Surgery
2301	Thoracic Surgery
2401	Urology
4001	Abdominal Surgery
4002	Acupuncture
4003	Addiction Medicine
4004	Adult Reconstructive Orthopedics
4005	Allergy
4006	Cardiovascular Surgery
4007	Clinical Pharmacology
4008	Diabetes
4009	Facial Plastic Surgery
4010	**General Practice**
4011	**Gynecology**
4012	Head & Neck Surgery
4013	Hepatology
4014	Homeopathic Medicine
4015	Immunology
4016	Legal Medicine
4017	Musculoskeletal Oncology
4018	Neuroradiology
4019	Nutrition
4020	**Obstetrics**
4021	Oral & Maxillofacial Surgery
4022	Orthopedic Surgery Of The Spine
4023	Orthopedic Trauma
4024	Pain Medicine
4025	Pediatric Allergy
4026	Pediatric Ophthalmology
4027	Pediatric Orthopedics
4028	Pediatric Surgery (Neurology)
4029	Pediatric Urology
4030	Psychoanalysis
4031	Radioisotopic Pathology
4032	Sports Medicine (Orthopedic Surgery)
4033	Traumatic Surgery
4034	Sleep Medicine
9001	Rotating Internship (Residency)
9999	Other - Please Specify

Curriculum Vitae

Cheryl A. Gibson, M.D.
23 Mansfield Ave.
Burlington Vermont 05401
Phone 802-863-9001
Fax 802-862-9637
[redacted]

EMPLOYMENT HISTORY

July 2000-present

Clinical Associate Professor
Department of Obstetrics and Gynecology
University of Vermont College of Medicine
Burlington, Vermont

Medical Director
Planned Parenthood of Northern New England
Williston, Vermont
Member Planned Parenthood Federation of America, National Medical Committee

July 1992-June 2000

Clinical Assistant Professor
Department of Obstetrics and Gynecology
University of Vermont College of Medicine
Burlington, Vermont

Associate Medical Director
Planned Parenthood of Northern New England
Williston, Vermont

September 1989-
May 1992

Assistant Professor and Director of Colposcopy Services
Department of OB/GYN, University of Vermont College of Medicine
Burlington, Vermont

Medical Director
Vermont Womens Health Center
Burlington, Vermont

July 1988-
June 1989

Clinical Instructor
Department of OB/GYN, University of Vermont College of Medicine
Burlington, Vermont

1978-1986

OB/GYN Nurse Practitioner and Clinical Supervisor
Planned Parenthood of Vermont
Burlington, Vermont

1977-1978

Nurse Coordinator
Planned Parenthood of Vermont
Burlington Vermont

Cheryl A. Gibson, M.D.

PROFESSIONAL CERTIFICATIONS

Board Certified, American College of OB/GYN, 1991.
National Board of Medical Examiners; Certification 1986, #308479.
NAACOG Certification as Outpatient OB/GYN Nurse Practitioner; 1980.

STATE LICENSURES

State of Vermont; 1986-present #42-0007465
State of New Hampshire; 1987-present #7539
State of Maine; 1991-present #013193

EDUCATION

Post Graduate Medical Education

OB/GYN Residency, Medical Center Hospital of Vermont June 1985-June 1989
Resident Teaching Award 1987,1988

Medical Education

M.D., University of Vermont College of Medicine, Burlington, Vermont
Graduated May 1985

Post Graduate Education

New Jersey College of Medicine and Dentistry/ Planned Parenthood Federation
Certificate, Family Planning Nurse Practitioner, 1978

Undergraduate Education

B.S., Professional Nursing, University of Vermont, 1977

PROFESSIONAL MEMBERSHIPS

American College of Obstetrics and Gynecology, Fellow, 1991-present
American Society of Gynecologic Laparoscopists, 1989-present
American Society for Colposcopy and Cervical Pathology, 1990-present
Association of Reproductive Health Professionals, 1992-present
American College of Obstetrics and Gynecology, Junior Fellow, 1986-1991
Vermont State Medical Society, 1985-present
American Nurses Association, 1977-1986
Vermont State Nurses Association, 1977-1986

Cheryl A. Gibson, MD

BIBLIOGRAPHY

Hughes,SA.,Sun D., Gibson C., Bellerose B., Rushing, L. Chen, H. Harlow, B., Genest, D. Sheets, E., Crum, C. "Managing Atypical Squamous Cells of Undetermined Significance (ASCUS): Human Papillomavirus Testing, ASCUS Subtyping, or Follow-up Cytology" , American Journal of Obstetrics and Gynecology, March 2002.

Gibson, C., Trask C., House, P. Smith SF., Foley, M., Nicholas C., "Endocervical Sampling: A Comparison of Endocervical Brush, Endocervical Curette and Combined Brush with Curette Techniques", Journal of Lower Genital Tract Disease, January 2001.

Brumsted, J., Kessler, C., Gibson, C.,Nakajima, S., Riddick, D., Gibson, M., "Comparison of Laparoscopy And Laparotomy for the Treatment of Ectopic Pregnancy", Obstetrics and Gynecology, May 1988.

Gibson, Cheryl, "From Policy to Preventive Services: A Successful Teenage Contraceptive Program", 1980 Papers- Planned Parenthood Federation World Conference, September, 1980.

RESEARCH

Coinvestigator in multicenter national trails tesing Mifipristone and Misoprostol for pregnancy termination,1996-1997.

Coinvestigator in multicenter national trails testing Methotrexate and Misoprostol for pregnancy termination, 1997.

7465 Pd $400 6

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

2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

1. **Your legal name:** GIBSON, CHERYL A

Last Name | First Name | Middle Name | Suffix

a. Have you ever legally changed your name? X Yes ___ No not since licenced as a physician

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

Last Name | First Name | Middle Name: | Suffix

b. Indicate your name, as it should appear on your license:
Gibson | Cheryl | A.
Last Name | First Name | Middle Name: | Suffix

RECEIVED
SEP 27 2004
VERMONT BOARD OF MEDICAL PRACTICE

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

3. **Home Address:**
same as below
(Street)

(City) (State) (Zip)

4. **Work Address:**
23 MANSFIELD AVE
BURLINGTON, VT 05401
(Street)

(City) (State) (Zip)

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

6. **Home Telephone Number with Area Code:** (802) 863-9001

7. Work Telephone Number with Area Code: (802) 863-9001

8. E-mail address: [redacted]

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

PART II

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

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

ME 1991
NH 1989

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

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

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

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

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

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

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

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

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

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

□ yes ☒ no

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

□ yes ☒ no

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

☒ yes □ no

PART III

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

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

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

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

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example,

you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

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

[redacted]

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

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

[redacted]

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

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

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

None reported

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

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

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

None reported

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

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

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.
11//1996

[redacted]

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

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

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

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

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

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

B. **Other Restrictions** ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

(Date) (Hospital) (State)

(Nature of Action) (Action) In lieu In settlement

(Reason for Action)

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

A. Judgments ☒ Check here if none

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

Judgement Arbitration
None reported

(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)

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

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, VT

1985

(School/Institution) (City) (State) (Year of Graduation)

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

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

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

Fletcher Allen Health Care ,VT

Obstetrics and Gynecology

1989

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

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

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

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

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1991, 2001

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

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

Month and year you started practicing as a physician? 6//1989

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

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

Fletcher Allen (FAHC, MCHV)

VT

(1989-)

(Name) (City) (State) (Year Started)

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

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☐ Check here if none

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

University of Vermont

Burlington, VT

Clinical Associate Professor

1989 - present

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

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont

Burlington, VT

Medical Students and residents

1989 - present

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

38. **Publications:** [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

None reported

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] ☒ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

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

Town or City State

41. **Translating Services** [26 VSA § 1368(a)(16)] ☒ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

None

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

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

A. Medicaid participation

Do you participate in the Medicaid program? ☒ yes ☐ no ☐ not applicable

B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☒ yes ☐ no ☐ not applicable

Part V

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

Date: 9/15/04

MD

Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

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

_____

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

(Question 15) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court Chittenden Superior Court

City and State Burlington Vermont

Charge Malpractice

Description Patient developed complications of Vaginal Surgery

Status In depositions and expert testimony / Discovery - pending

Conviction? _____ Yes X No Date _____

Plea? _____ Yes _____ No Date _____

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 23-25) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

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

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim pending - see questions 20 + 22.

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 National Union Fire Insurance Co

Claimant name C. + E. Durivage

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate: See attached
1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

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

_____

Your role (circle one):

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

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 9/15/04

PD
450.00

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

2006 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0007465

1. **Your legal name:**

   Cheryl A Gibson

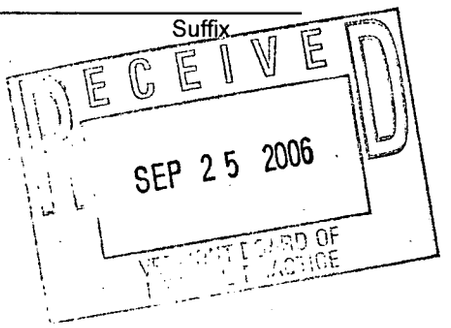
   a. Have you ever legally changed your name? ___Yes X No

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

   _____
   Last Name First Name Middle Name: Suffix

   b. Indicate your name, as it should appear on your license:

   _____
   Last Name First Name Middle Name: Suffix



2. **Your Date of Birth:**

3. **Home Address and email address:**

   [redacted]

4. **Work Address:**

   23 Mansfield Avenue
   Burlington, VT 05401

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

6. **Home Telephone Number with Area Code:** (_____)_____

7. **Work Telephone Number with Area Code:** (802) 863-9001

8. **E-mail address (if not appearing in #3):**

   [redacted]

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

PART II

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

10. **Do you hold, or have you ever held, a medical license (including temporary) in any other state?**
☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, e.g. conditioned, restricted, limited)
ME 1991				Active
NH 1989				Active

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

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

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

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

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

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

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

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

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

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

20. **Are you presently or have you ever been a defendant in a criminal proceeding?**
☐ yes ☒ no

PART III

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

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

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

[redacted]

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

[redacted]

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

[redacted]

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

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

[redacted]

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

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

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

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

None reported

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

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

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

None reported

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

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

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

None reported

[redacted]

(Date) (Final Disposition - Summary)

29. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]

☒ Check here if none

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

None reported

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

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

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

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

None reported

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

B. **Other Restrictions** ☒ Check here if none

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

None reported

(Date) (Hospital) (State)

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

(Reason for Action)

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

A. **Judgments** ☒ Check here if none

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

None reported

☐ Judgement ☐ Arbitration

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

B. Settlements ☐ Check here if none

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

None reported

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

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

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, VT

1985

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

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

Fletcher Allen Health Care ,VT

Obstetrics and Gynecology

1989

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)

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

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

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

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1991, 2001

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1101	OB/Gyn	☒ yes ☐ no	ABOG	1991	2001

		☐ yes ☐ no			

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

Month and year you started practicing as a physician? **6//1989**

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

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

Fletcher Allen (FAHC, MCHV)
VT
(1989-)

(Name) (City) (State) (Year Started)

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

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☐ Check here if none

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

University of Vermont
Burlington, VT
Medical Students and residents
1989 - present

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

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT
Medical Students and residents
1989 - present

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

38. Publications: [26 VSA § 1368(a)(13)] ☐ Check here if none

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

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] □ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

(Activities or Awards)

(Activities or Awards)

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] □ Check here if none

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

41. **Translating Services** [26 VSA § 1368(a)(16)] ☒ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? □ Not applicable

If yes, please describe here the translating services available:

None

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

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

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes □ no □ not applicable

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes □ no □ not applicable

Part V

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

Date: 9/13/06

Applicant's Signature

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

Physician Profile Update

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

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

OMIT FROM PROFILE

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

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

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

_____

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

(Question 15) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances_____

_____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances_____

_____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status_____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 23-24) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

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

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim

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

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

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

_____

_____

_____

_____

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

Your role (circle one):

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

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 9/13/06

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

2008 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0007465

1. **Your legal name:**

Cheryl A Gibson

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

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

Last Name	First Name	Middle Name:	Suffix

b. Indicate your name, as it should appear on your license:

Last Name	First Name	Middle Name:	Suffix

2. **Your Date of Birth:** [redacted]

RECEIVED
SEP 15 2008
Vermont Board of Medical Practice

3. **Home Address and email address:**

[redacted]

4. **Work Address:**
23 Mansfield Avenue
Burlington, VT 05401

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

6. **Home Telephone Number with Area Code:** (802) 863-9001

7. **Work Telephone Number with Area Code:** (802) 863-9001

8. **E-mail address (if not appearing in #3):** [redacted]

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

PART II

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

10. **Do you hold, or have you ever held, a medical license (including temporary) in any other state?**
☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
ME 1991				
NH 1989				

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

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

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, VT
1985

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

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

Fletcher Allen Health Care ,VT
Obstetrics and Gynecology
1989

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

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

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

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1991, 2001

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1101	OB/gyn	☒ yes ☐ no	Am Board OB/gyn	1991	2001,
		☐ yes ☐ no			2007, 2008

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

Month and year you started practicing as a physician? 6//1989

15. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

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

Fletcher Allen (FAHC, MCHV)

VT
(1989-)

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

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

[redacted]

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

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

[redacted]

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

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

[redacted]

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

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

[redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

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

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

None reported

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

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

None reported

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

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

None reported

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

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

None reported

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

A. **Revocation/Involuntary Restrictions** ☒ Check here if none

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

None reported

B. **Other Restrictions** ☒ Check here if none

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

None reported

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

A. **Judgments** ☒ Check here if none

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

None reported

B. **Settlements** ☒ Check here if none

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

None reported

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

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

A. Appointments ☐ Check here if none

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

University of Vermont
Burlington, VT
Clinical Associate Professor
1989 - present

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT
Medical Students and residents
1989 - present

39. **Publications:** [26 VSA § 1368(a)(13)] □ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. **Activities** [26 VSA § 1368(a)(14)] □ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

41. **Practice Setting** [26 VSA § 1368(a)(15)] □ Check here if none

What is the location of your primary practice setting?

BURLINGTON, VT

42. **Translating Services** [26 VSA § 1368(a)(16)] □ Check here if none

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

If yes, please describe here the translating services available:

None

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

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes □ no

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes □ no

Part V

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

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

Date: 9/2/08 _____ MD
Applicant's Signature

Physician Profile Update

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

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

OMIT FROM PROFILE

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

Again, thank you for your cooperation.

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 _____ MD Date 9/2/08

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

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

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

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

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

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Date: 9/2/08 _____

Cheryl A Gibson MD
VT # 7465

PLEASE NOTE:

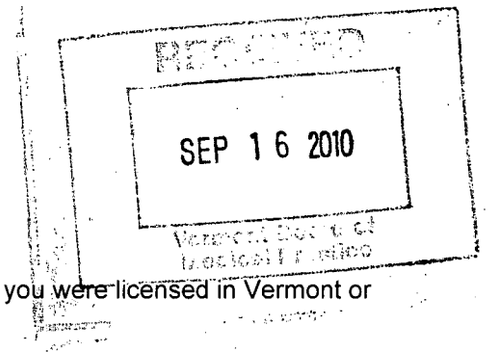
In accordance with 4 V.S.A. § 1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

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

2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0007465



1. **Your legal name:**

   Cheryl A Gibson

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

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

   Last Name | First Name | Middle Name: | Suffix

   b. Indicate your name, as it should appear on your license:

   Gibson | Cheryl | Ann |

   Last Name | First Name | Middle Name: | Suffix

2. **Your Date of Birth:** [redacted]

3. **Mailing Address and email address:**

   [redacted]

4. **Work Address:**
   23 Mansfield Avenue
   Burlington, VT 05401
   [redacted]

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

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

7. **Work Telephone Number with Area Code:** (802) 863-9001

8. **E-mail address (if not appearing in #3):**

_____

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

□ yes □ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? ☑ yes □ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☑ yes □ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
ME	1991	MD		
NH	1989	MD		

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

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

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF VERMONT, VT
1985

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

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

Fletcher Allen Health Care ,VT
Obstetrics and Gynecology
1989

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

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

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

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1991, 2008 , 2009

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		□ yes □ no			
		□ yes □ no			

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

Month and year you started practicing as a physician? 6//1989

15. Hospital Privileges [26 VSA § 1368(a)(11)] □ Check here if none

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

Fletcher Allen (FAHC, MCHV)
VT
(1989-)

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

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

[redacted]

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

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
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"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.

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

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

[redacted]

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

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

[redacted]

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

31. A[redacted]engaged in the illegal use of controlled substances?

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

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

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

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

None reported

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

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

None reported

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

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

None reported

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

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

None reported

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

A. **Revocation/Involuntary Restrictions** ☑ Check here if none

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

None reported

B. **Other Restrictions** ☑ Check here if none

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

None reported

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

A. **Judgments** ☑ Check here if none

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

None reported

B. **Settlements** ☑ Check here if none

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

None reported

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

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

A. Appointments □ Check here if none

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

University of Vermont
Burlington, VT
Clinical Associate Professor
1989 - present

B. Teaching □ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT
Medical Students and residents
1989 - present

39. Publications: [26 VSA § 1368(a)(13)] □ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. Activities [26 VSA § 1368(a)(14)] □ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

41. Practice Setting [26 VSA § 1368(a)(15)] □ Check here if none

What is the location of your primary practice setting?

BURLINGTON, VT

42. Translating Services [26 VSA § 1368(a)(16)] □ Check here if none

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

If yes, please describe here the translating services available:

None

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

A. Medicaid participation

Do you participate in the Medicaid program? ☑ yes □ no

B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☑ yes □ no

Part V

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

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

Date: 9/1/10

Applicant's Signature

Physician Profile Update

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

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

OMIT FROM PROFILE

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

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

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

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

_____

(Question 18) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances_____

_____

(Question 19) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

_____

_____

(Question 20) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

(Question 23) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

(Question 24) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

(Question 25) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 29-30) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

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

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

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

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

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

_____

_____

_____

_____

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

_____

Your role (circle one):

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

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court_____

Court's location_____

Docket number_____

Date the action was filed_____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

_____

_____

_____

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

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

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

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

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

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

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

* *

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 045470-0070.**

I consent:

_____ _____

Signature Date

_____

Name (printed or typed)

_____ _____

License type (profession) Vermont License Number

_____

Mailing Address

_____

City, State, Zip

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

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

I _____ **(print name)** hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
PO Box 70
Burlington, VT 05402-0070

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

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

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

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

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

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Signature: _____ Date: 9/1/10

PLEASE NOTE:

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

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date 9/1/10

Renewal - 042.0007465

Name	Cheryl A. Gibson
Credential	042.0007465

Renewal Introduction

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
(802)657-4220 or 800-745-7371

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@vdh.state.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- enter, correct or update all information
- print legibly or type your answers
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to "yes" answers in Parts II - IV
- write your name and license number on each attachment
- do not delegate this important task to any other person. False statements on this form may be grounds for charges of unprofessional conduct.

Be sure to submit:

- completed application
- completed Form A
- completed *Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions*, whether or not you have children.
- any other attachments
- payment in the amount of $500 to the **Vermont Department of Health**
- ***LATE FEE:*** Applications received after the license expiration date will be assessed a $25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:
Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
Gibson

2. First Name:
Cheryl

3. Middle Name:
A.

4. Have you ever legally changed your name?
Yes

5. If yes, enter your former name and other name(s) under which you were licensed in Vermont or elsewhere:

Previous Name	From Month	From Year	To Month	To Year	Reason for Change
Cheryl G Madigan	June	1984	April	1988	divorce

6. Date of Birth:
[redacted]

7. Enter your MAILING ADDRESS information:

Attention
Street 1775 Williston Rd Suite 110,
City SOUTH BURLINGTON **State** VT **Zip** 05403 **Country** United States
E-mail Address [redacted]
Telephone [redacted] **Alternate Phone (e.g. Pager)**

8. Enter your PUBLIC ACCESS address information:

Attention
Street 1775 Williston Rd Suite 110,
City SOUTH BURLINGTON **State** VT **Zip** 05403
Country United States
Telephone (802) 863-9001
E-mail Address
Alternate Phone (e.g. Pager)

Renewal Part II

9. Were you in active clinical practice in the past 12 months?
Yes

10. Do you hold, or have you ever held, a license or certification as a medical practitioner in Vermont or any other state?
Yes

11. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Maine	MD	013193	02/23/2010	04/30/2012	Expired

12. Medical Professional Schools [26 VSA § 1368(a)(7)]
Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: University of Vermont **State**: Vermont **Country**: **School Type**: Medical School	01/01/1985

Degree: MD	

13. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]
Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Fletcher Allen Health Care	01/01/1989	Obstetrics and Gynecology

14. Specialty Board Certification [26 VSA § 1368(a)(9)]
Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/2008	12/31/2012
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/1991	01/01/2008

15. **Years of Practice**
What year did you start practicing as a medical professional?
1989

16. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]
List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date
Fletcher Allen (FAHC, MCHV)	Vermont	01/01/1989

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

17. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
No

18. State:

19. Year:

20. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

21. Denied certificate to practice medicine or any other healing art - Upload documents

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?
No

23. State:

24. Year:

25. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:

26. Please upload any documents you have that are relevant to this matter.

27. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
No

28. State:

29. Year:

30. Circumstances:

31. Please upload any documents you have that are relevant to this matter.

32. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
No

33. Name of organization involved:

34. Date:

35. Duration:

36. Action Taken (add all that apply):

37. Circumstances:

38. Please upload any documents you have that are relevant to this matter.

39. Have you ever been denied the privilege of taking an examination before any state medical examining board?
No

40. State:

41. Year:

42. Circumstances under which examination privileges denied:

43. Please upload any documents you have that are relevant to this matter.

44. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
No

45. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:

46. Discontinued Education, Training, or Clinical Practice - Upload documents:

47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?
No

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances:

52. Please upload any documents you have that are relevant to this matter.

53. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
No

54. Institution involved:

55. Location:

56. Year:

57. Circumstances:

58. Please upload any documents you have that are relevant to this matter.

59. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
No

60. Name of organization involved:

61. Type of restriction:

62. Date:

63. Circumstances of restriction

64. Please upload any documents you have that are relevant to this matter.

65. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice.
No

66. Please provide a general description of your practice of internet prescribing:

67. Are you presently, or have you ever been, a defendant in a criminal proceeding?
No

68. Court:

69. City and state:

70. Charge:

71. Description:

72. Status:

73. Date:

Renewal Part III

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained.

74. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?

75. Licensing or certification board:

76. Date:

77. Location of Licensing Board:

78. Circumstances:

79. Please upload any documents you have that are relevant to this matter.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled

Substances Act or other provisions of federal law.

80. Do you have a medical condition that in any way impairs or potentially impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

81. In explaining "Yes" answer to the previous question, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

82. Please upload any documents you have that are relevant to this matter.

83. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

[redacted]

84. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

85. Please upload any documents you have that are relevant to this matter.

86. Are you currently engaged in the illegal use of controlled substances?

[redacted]

87. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

88. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

89. Treating organization:

90. Address:

91. Telephone:

92. Type of diagnosis, condition or treatment - field of practice - use of chemical substances:

93. Dates of illness or dependency (from, to):

94. Dates of treatment (from, to):

95. Name of rehabilitation/professional assistance or monitoring program:

96. Address:

97. Telephone:

98. Contact person at Program:

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

Renewal Part IV

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile.

It is very important for us to receive copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of actions taken.

If you have been convicted of an alcohol or drug related crime, you must contact the Vermont Practitioners Health Program to arrange for a confidential evaluation (802-223-0400). The evaluation will need to be received by this Board prior to licensure.

99. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets)? For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction.

No

100. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description

101. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Have there been any charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction?

No

102. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continue without finding by a court of competent jurisdiction.

Date of Charges	Court	City	State	Description of Charges

103. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have there been any formal charges served, findings, conclusions, and/or orders of the Board of Medical Practice (including stipluations), and/or final disposition of such matters by the courts, if appealed?

No

104. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipluations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary

105. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have there been any formal charges served against you by licensing or certification authorities of other states?

No

106. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**

Date of Disposition	Licensing Authority	City	State	Description of Disposition

Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

107. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?
No

108.
A. Revocation/Involuntary Restrictions
Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please upload copies of papers fully documenting these matters.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction

109. Have your hospital privileges ever been restricted, or have you ever resigned or not renewed your medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital?
No

110.
B. Other Restrictions
Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please upload copies of papers fully documenting these matters.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement

111. **Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]** Have you ever been involved in a Malpractice Liability Claim? Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.
No

112.
A. Judgments
Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Date of Judgment

113.
B. Settlements Please provide a description of all settlements of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

Date Of Settlement

Medical Malpractice Claim
For each response provided in the previous Medical Malpractice Judgements and/or Settlements questions you must complete the form located **here**. Please download the form, complete it for each response, and then upload to each respective response. **This information is required for each and every response provided for Judgements and/or Settlements.**

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: Providing the following Appointments and Teaching information is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

114. **A. Appointments** Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	Year Started	Year Ended
University of Vermont College of Medicine	Burlington	Vermont	OB/GYN Faculty	1989	

115. **B. Teaching** Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

School/Institution	City	State	Nature of Teaching	Year Started	Year Ended

University of Vermont College of Medicine/Fletcher Allen Health Care	Burlington	Vermont	Teaching medcial students and residents	1989	

116. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/2008	12/31/2102
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/1991	01/01/2008

117. Activities [See 26 VSA § 1368(a)(14)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your professional or community service activities and awards.

Activity or Award

118. Provide the following information for each practice location. Be sure to indicate which is to be your primary practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
None reported	BURLINGTON	Vermont	Yes		Yes	Yes

Statement of Good Standing

119.

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

1. 60 days or fewer have elapsed since the date a judgment was issued; or
2. the person is in compliance with a repayment plan approved by the judiciary.

Yes

120. Date:
09/10/2012

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the

annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

121. You must select one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

122. You must select one of the two statements below regarding taxes:
I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both.)

The disclosure of your social security number is manditory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

123. Social Security Number:
[redacted]

124. Date of Birth:
[redacted]

125. I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.
Yes

126. Date:
09/10/2012

Renewal Payment

127. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.
Mail Payment

Review

Renewal - 042.0007465

Name	Cheryl A. Gibson
Credential	042.0007465

Renewal Introduction

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
(802)657-4220 or 800-745-7371

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4223, 800-745-7371 or medicalboard@state.vt.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.
- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to Malpractice

Malpractice Claim Documentation – If you have reportable malpractice history, you must download Form A, carefully complete a form for each case, and submit it along with the required documentation. For your application, reportable malpractice includes:

  - Pending claims that have not been resolved.
  - Cases that resulted in a payment by you or on your behalf, whether as a settlement, arbitration award, or court verdict.
  - Note that you need not report cases that were resolved in your favor with no payment by you or on your behalf. This includes cases that were withdrawn without payment, dismissed without payment, or resolved by a verdict in your favor.

Be sure to submit:
  - completed Form A, if applicable
  - payment in the amount of $500 to the **Vermont Department of Health**
  - ***LATE FEE:*** Applications received after the license expiration date will be assessed a $25 late fee.

Please Note:
- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:
Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
   Gibson

2. First Name:
Cheryl

3. Middle Name:
A.

4. Have you ever legally changed your name?
Yes

5. If yes, enter your former name and other name(s):

Previous Name	From Month	From Year	To Month	To Year	Reason for Change
Cheryl G Madigan	June	1984	April	1988	divorce

6. Date of Birth:
[redacted]

7. Please provide your preferred email address for receiving important correspondence from this medical board
cgibson@vtgyn.com

8. Enter your MAILING ADDRESS information:

Attention
Street 1775 Williston Rd Suite 110,
City SOUTH BURLINGTON **State** VT **Zip** 05403 **Country** United States
E-mail Address [redacted]
Telephone [redacted] **Alternate Phone (e.g. Pager)**

9. Enter your PUBLIC ACCESS address information:

Attention
Street 1775 Williston Rd Suite 110,
City SOUTH BURLINGTON **State** VT **Zip** 05403
Country United States
Telephone (802) 735-1252
E-mail Address [redacted]
Alternate Phone (e.g. Pager)

Renewal Part II

10. Were you in active clinical practice in the past 12 months?
Yes

11. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state?
Yes

12. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Maine	MD	013193	02/23/2010	04/30/2012	Expired

13. Medical Professional Schools [26 VSA § 1368(a)(7)]
Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date

School Name: University of Vermont **State**: Vermont **Country**: United States **School Type**: Medical School **Degree**: MD	01/01/1985

14. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]
Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Fletcher Allen Health Care	01/01/1989	Obstetrics and Gynecology

15. Specialty Board Certification [26 VSA § 1368(a)(9)]
Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/2008	12/31/2015
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/1991	01/01/2008

16. **Years of Practice**
What year did you start practicing as a medical professional?
1989

17. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]
List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date	End Date
Fletcher Allen (FAHC, MCHV)	Vermont	01/01/1989	

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

18. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art in any jurisdiction? If yes, identify the US state or territory, or Canadian territory or province that denied the application and the year in which it was denied, and provide a summary of the circumstances and reason for denial, in the following questions. Upload documents related to the denial where indicated.
No

19. State:

20. Year:

21. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

22. Denied certificate to practice medicine or any other healing art - Upload documents

23. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art, in any jurisdiction? If yes, identify the US state or territory, or the Canadian territory or province in which you withdrew the application and the year in which it was withdrawn, and provide a summary of the circumstances and reason for the withdrawal, in the following questions. Upload documents related to the withdrawal where indicated.
No

24. State:

25. Year:

26. Circumstances under which the application for license or certificate was withdrawn, specifying your reason or reasons for withdrawl

27. Withdrawal of application for license or certificate - Upload documents:

28. Have you ever voluntarily surrendered a license or certificate to practice medicine or any other healing art, in any jurisdiction, after having been notified of an investigation that had not yet been resolved or in lieu of disciplinary action? “Surrendered a license” includes any form of voluntary abandonment of the right to practice in a jurisdiction, regardless of the terminology used, and includes allowing a license to lapse after learning of an investigation by a licensing authority. If yes, identify the state, territory, or province in which you surrendered a license or certificate and the year in which it was surrendered or you resigned, and provide a summary of the circumstances in the following questions. Upload documents related to the surrender of license where indicated. NOTE: If you let a license lapse because you no longer practiced in a state, and you had no knowledge of a pending investigation by the licensing authority, that would not constitute surrender of your license.
No

29. State:

30. Year:

31. Circumstances:

32. Voluntary surrendered license or certificate to practice medicine or any other healing art - Upload documents:

33. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions. If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated.
No

34. Name of entity involved:

35. Date:

36. Duration:

37. Action Taken (add all that apply):

38. Circumstances:

39. Disciplinary charges or actions - Upload documents:

40. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated.
No

41. State:

42. Circumstances surrounding denial of examination privileges and reason therefore provided by the board that denied you the privilege of taking an exam:

43. Denial of examination privileges - Upload documents:

44. Have you ever discontinued your education, training, or medical practice for a period of more than three (3) months, NOT including periods occurring solely during premedical education?
No

45. If yes, please explain, including the dates during which your education, training, or practice was discontinued.

46. Discontinued Education, Training, or Clinical Practice - Upload documents:

47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?
No

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances surrounding dismissal, suspension, or request for you to leave the training program(s) before completion?

52. Are you currently the subject of an investigation or peer review by any licensing authority, hospital, medical staff group, health care facility, professional association, or other body that has authority to take actions regarding: your right to practice medicine or any other healing art; your employment practicing medicine or any other healing art; or your professional qualifications (e.g., specialty board certification)? If yes, provide the name of the entity conducting the investigation, its location, the date you learned about the investigation, and the circumstances that triggered the investigation in the following questions and upload any relevant documentation you have such as a letter notifying you of the investigation where indicated.
No

53. Entity Investigating:

54. Location of entity investigating:

55. Date (month and year) your learned of the investigation?

56. Describe the event under investigation and the circumstances triggering the investigation:

57. Open investigation by licensing authority, hospital, medical staff group, health care facility, professional association, or professional certifying organization – upload documents.

58. Has your privilege to possess, dispense, administer, or prescribe controlled substances or other prescription medications or devices ever been suspended, revoked, denied, restricted, or surrendered as the result of an investigation or action by any governmental entity at any time? If yes, provide the entity that acted on your privilege to prescribe, the nature of the limitation or action, the date of the action, and a description of the circumstances underlying the action in the following questions, and upload any relevant documentation you have regarding the action where indicated.
No

59. Entity that took action on prescribing privileges:

60. Action taken:

61. Date of action taken regarding prescribing privileges:

62. Circumstances underlying action on prescribing rights:

63. Action taken on prescribing privileges – upload documents.

64. Are you presently a defendant in a criminal proceeding?
No

65. Court:

66. City and state:

67. Charge:

68. Description:

69. Status:

70. Date:

71. Defendant in criminal proceeding - Upload Documents:

72. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing for patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions.
No

73. If you answered yes to the preceding question, provide a general description of any prescribing you do in response to electronic communications.

Renewal Part III

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained.

74. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.
■

75. Jurisdiction:

76. Description of matter under Investigation:

77. Date you became aware of Investigation:

78. Upload any documents you may have relating to the matter under investigation:

79. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and

a description of the matter under investigation in the following questions and upload relevant documents where indicated.

80. Licensing or certification board conducting investigation:

81. Date of event(s) under investigation:

82. Nature of event(s) under investigation:

83. Pending licensing board investigation – upload documents.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

84. Do you have a medical condition that in any way impairs or potentially impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

85. In explaining "Yes" answer to the previous question, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

86. Please upload any documents you have that are relevant to this matter.

87. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

88. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have

participated or do participate in a monitoring program.

89. Please upload any documents you have that are relevant to this matter.

90. Are you currently engaged in the illegal use of controlled substances?

[redacted]

91. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

92. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

93. Treating organization:

94. Address:

95. Telephone:

96. Type of diagnosis, condition or treatment - field of practice - use of chemical substances:

97. Dates of illness or dependency (from, to):

98. Dates of treatment (from, to):

99. Name of rehabilitation/professional assistance or monitoring program:

100. Address:

101. Telephone:

102. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

Applicants with other events or actions that must be reported (e.g., a criminal conviction) must provide documentation of each event. It is very important for the Board to receive copies of court papers, licensing authority decisions, or similar documentation, as noted below. The Board will not act on an application that lacks required documentation**. If any reportable event involves alcohol or drugs in any way, you must contact the Vermont Practitioner Health Program to arrange for an evaluation**. **The Board will not act on an application that is missing a required evaluation.** You may contact VPHP at (802) 223-0400. Information about

VPHP is online at: **http://www.vtmd.org/health-professional-wellness-and-recovery-programs**.

103. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crime? This includes both misdemeanors and felonies; it includes crimes such as driving under the influence (DUI), but not non-criminal traffic offenses such as speeding or parking tickets. For purposes of this question, "convicted" means that you pleaded guilty or were adjudged guilty by a court of competent jurisdiction. For this question, it also includes the loss of a driver's license as a result of a civil process triggered by the refusal to provide a sample of breath for the purpose of screening for driving while under the influence of alcohol.

No

104. **Criminal Convictions continued** [See 26 VSA § 1368(a)(1)] Provide information regarding each conviction as defined above. **In addition to entering the information here, you must submit copies of documents that show information about the crime (s) of which you were convicted and the sentence imposed, to include the police report, any ticket/citation/indictment/arrest record, and final disposition.**

Date of Conviction	Court of Conviction	City	State	Description

105. Nolo Contendere/Matters [See 26 VSA § 1368(a)(2)]
Have you ever had a criminal involvement that resulted in a case resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

106. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Provide information regarding each criminal involvement resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges

107. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

108. Vermont Board of Medical Practice Matters continued [See 26 VSA § 1368(a)(3)]
Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date	Final Disposition Summary

109. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

110. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition	Licensing Authority	City	State	Description of Disposition

Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

111. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?

No

112.
A. Revocation or Restriction of Hospital Privileges Information
Provide information about each instance in which hospital privileges were revoked or involuntarily restricted for reasons related to competence or character. Provide documentation that shows the date, basis for the action, the authority who took the action, and the action taken.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction

113. Have you ever, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character, done any of the following:

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?
No

114. B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information
Provide information about each instance in which you resigned or did not renew medical staff membership, or you had hospital privileges restricted, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character? Provide documentation that shows the date, the hospital, the basis for and nature of the case, and the terms of settlement, if any.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement

115. Medical Malpractice Court Judgments & Settlements Have you ever had a medical malpractice claim against you that is still pending or that resulted in any of the following:

- a court judgment against you; or

- an arbitration award or a settlement that you or another party paid on your behalf?

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located **here** Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.
No

116. **A. Judgments**
Provide the information requested in the following table for each case in which there was a court judgment or arbitration award against you.

Date of Judgment	Number of Judgments

117. **B. Settlements**
Provide the information requested in the following table for each case in which you were named as a defendant and in which a settlement was paid by you or on your behalf.

Date Of Settlement

118. **C. Pending Cases**
Provide the information requested in the following table for each case that is currently pending against you.

Date

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: Providing the following Appointments and Teaching information is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

119. **A. Appointments** Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	Year Started	Year Ended
University of Vermont College of Medicine	Burlington	Vermont	Clinical Associate Professor	2008	

120. **B. Teaching** Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

School/Institution	City	State	Nature of Teaching	Year Started	Year Ended

121. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date

122. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

Activity or Award

123. Provide information about each current and planned practice location, wherever located. Indicate which is planned to be your primary practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
Vermont Gynecology	So. Burlington	Vermont	Yes		Yes	Yes

Statement of Good Standing

124.

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that either:

A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or

B. I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

1. 60 days or fewer have elapsed since the date a judgment was issued; or
2. the person is in compliance with a repayment plan approved by the judiciary.

Yes

125. Date:
09/16/2014

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

126. You must select one of the two statements below regarding child support regardless whether or not you have children:

order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

127. You must select one of the two statements below regarding taxes:

I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both.)

The disclosure of your social security number is manditory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

128. Social Security Number:

[redacted]

129. Date of Birth:

[redacted]

130. I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Yes

131. Date:

09/16/2014

Continuing Medical Education Requirements

Each applicant for renewal must certify that he or she meets the requirements for CME as indicated by one of the statements below, a – f. Note that for purposes of this certification, completion of an activity includes taking the steps necessary to receive credit and obtain documentation of completion. If you cannot certify that you are eligible to renew your license because one of the statements applies to you, then you must contact the Board of Medical Practice to discuss your renewal application. You are not required to submit documentation of your CME activities with your renewal application, but licensees are subject to audit and may be asked to submit such documentation during the next two licensing cycles (for this renewal, through November 30, 2018).

The Rules for Continuing Medical Education are available on the Board's website at:
http://healthvermont.gov/hc/med_board/documents/FinalCMERules10.1.12_000.pdf

a) I do not have to complete CME for this renewal because I was licensed as an MD in Vermont for the first time on or after December 1, 2013.

b) I was licensed as an MD for the first time in Vermont between December 1, 2012 and November 30, 2013. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

c) I have completed at least 30 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances.

d) I am a member of the armed forces of the United States and I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) one year or more. Accordingly, I am not required to certify that I completed CME for this renewal.

e) I am a member of the armed forces of the United States and during the period from June 1, 2012 to November 30, 2014, I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) less than one year. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

f) I have not completed the required CME for renewal, but I have submitted a make-up plan that I have signed and that was approved by the Executive Director of the Board.

132. I hereby certify that I have satisfied the Vermont Board of Medical Practice requirements for CME as indicated in the above statement. Select the one that best applies.
C

Workforce Survey

"Since 1999, the State of Vermont has been conducting a census of some professions every two years as part of relicensing. This has allowed us to monitor changes in Vermont's health care workforce. In 2012, the Legislature enacted a law to make work force data collection mandatory for all health care professions at license renewal as a necessary part of health care reform and planning for our health care future. We would like to thank you for your participation in this census."

You must complete the workforce survey before you may complete your application to renew your license. The mandatory workforce survey is accessed by clicking **here**

133. I hereby certify that I have completed the workforce survey per the above instructions
Yes

Renewal Payment

134. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.
Employer Pay by Check

Review