State of Vermont
Board of Medical Practice

THIS IS TO CERTIFY

that Kym Boyman, M.D.

a graduate of the University of Vermont, 1999

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

Chair: Elizabeth A. Turner, M.D., J.D.

Secretary: Hilton H. Dier, Jr.

License Number 42-0010597

Burlington

Date: June 4, 2003
Received and duly recorded.
Vermont Department of Health

10597 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:** KYM, BOYMAN MARGARET

Last Name | First Name | Middle Name | Suffix

a. Have you ever legally changed your name? ✓ Yes ___ No

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

BOYMAN | KIM | MARGARET

Last Name | First Name | Middle Name: | Suffix

(Note: I have never been licensed under this name. The change was years ago.)

b. Indicate your name, as it should appear on your license:

BOYMAN | KYM | MARGARET

Last Name | First Name | Middle Name: | Suffix

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

3. **Home Address:** [redacted]

(City) (State) (Zip)

4. **Work Address:** [redacted]

23 Mansfield Ave.
(Street)

Burlington VT 05401
(City) (State) (Zip)

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

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

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

None reported

State	License Number	Type of License	Date Issued	Status (Active or Inactive)
NH	12128	MD	11/5/03	Active
ME	016345	MD	11/21/03	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]

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.
None reported

(Date) (Final Disposition - Summary)

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

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

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

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

A. Revocation/Involuntary Restrictions ☑ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

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

B. Other Restrictions ☑ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

(Date) (Hospital) (State)

(Nature of Action) (Action)

In lieu In settlement

(Reason for Action)

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

A. Judgments ☑ Check here if none

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

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

1999

(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

2003

(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

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? 2003

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

(2003-)

(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.

Vermont Women's Choice

Staff Physician

Women's Health Care Service/Fletcher Allen Health Care

Burlington, VT

Attending Physician

University of Vermont

Burlington, VT

~~Assistant~~ Director, Medical Student Clerkship

University of Vermont

Burlington, VT

Cli

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

B. Teaching □ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

University of Vermont/ Fletcher Allen Health Care | Burlington | VT | Clinical Assistant Professor | 2003 to 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

- ACOG Vermont Junior Fellow Section Chair 2002
- Gold Foundation Humanism and Excellence in Teaching Award 2002
- AMWA Gender Equity Award 2003
- Organon Resident Research Award for outstanding Research in Women's Health. 2003

(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: 9/23/04 _____ _____
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 Fairfax County General District Court

City and State Fairfax, Virginia

Charge Obstruct Free Passage

Description Arrested for an act of civil disobedience

11/18/91

_____

Status Charge dismissed 9/11/92

_____

Conviction? _____ Yes X No Date _____

FAIRFAX COUNTY

☐ General District Court ☒ Criminal ☐ Traffic
☐ Juvenile and Domestic Relations District Court

TO ANY AUTHORIZED OFFICER:

You are hereby commanded in the name of the Commonwealth of Virginia forthwith to arrest and bring the Accused before this Court to answer the charge that the Accused, within this city or county, on or about November 18th , 1991 (DATE) did unlawfully in violation of Section 18.2-404, Code of Virginia: Did unreasonably , and unnecessarily , obstruct tne free passage of others :

check if applicable: ☐ commercial motor vehicle ☐ hazardous materials

I, the undersigned, have found probable cause to believe that the Accused committed the offense charged, based on the sworn statements of OfficerP.J.O'Hara EIN#1618 Fairfax County Police Dept. Complainant.

Execution by summons ☐ permitted at officer's discretion XX not permitted.

about 7:15 A.M. November 18th , 1991
DATE AND TIME ISSUED

WARREN B. BROWN 003

☐ CLERK ☐ MAGISTRATE ☐ JUDGE

A COPY TESTE:
NANCY L. LAKE, CLERK
FAIRFAX COUNTY GENERAL
DISTRICT COURT
BY: _____ DEPUTY CLERK

Original retained in the Clerk's Office of the General District Court of Fairfax County, Virginia

SUMMONS (If authorized above and by serving officer)

You are hereby commanded to appear before this court located at _____

on _____ at _____ AM/PM

I promise to appear in accordance with this Summons.

_____ ACCUSED

WARNING TO ACCUSED: You may be tried and convicted in your absence if you fail to appear in response to this Summons. Willful failure to appear is a separate offense. SIGNING THIS NOTICE DOES NOT CONSTITUTE AN ADMISSION OF GUILT.

FORM DC-314 6/90 (114:9-015 7/91)

December 13th , 1991 9:30 A;M

4110 CHAIN BRIDGE ROAD FAIRFAX VA 2203(

ACCUSED:
Boyman , Kym Margaret
[redacted]

COMPLETE DATA BELOW IF KNOWN

RACE	SEX	BORN	HT FT.	HT IN.	WGT	EYES	HAIR
W	F	[redacted]	5	8	135	HazBro	

SSN [redacted]

Commonwealth of Virginia

WARRANT OF ARREST

CLASS One MISDEMEANOR

☒ EXECUTED by arresting the Accused named above on this day:

☐ EXECUTED by summoning the Accused named above on this day:

11-18-91
DATE AND TIME

O'HARA, P.I.
ARRESTING OFFICER

#1618 FFX. Co. P.D. 029
BADGE NO., AGENCY AND JURISDICTION

for _____ SHERIFF

Attorney for the Accused:
6P-11-P

Con 8/3/92
50 hrs
a/s

☐ Motion to Change Bond on: .....
☑ changed to $ .....
☐ no change

JUDGE

The Accused was this day:
☐ tried in absence
☐ present

Attorneys Present:

PROSECUTING ATTORNEY (NAME)

DEFENDANT'S ATTORNEY (NAME)
☐ NO ATTORNEY
☐ ATTORNEY WAIVED

The Accused PLEADED:
☐ not guilty
☐ nolo contendere
☐ guilty

And was TRIED and FOUND by me:
☐ not guilty
☐ guilty as charged
☐ guilty of .....

And was FOUND by me to be:
☐ driving a commercial motor vehicle
☐ carrying hazardous materials

☑ I ORDER the charge dismissed
☑ I ORDER a nolle prosequi on Commonwealth's motion

☐ I impose the following Sentence: 91022778
☐ FINE of $..... with $..... suspended,
☐ JAIL sentence of ..... imposed with ..... suspended conditioned upon being of good behavior and keeping the peace.
☐ Serve jail sentence on weekend beginning .....
☐ Work release authorized if eligible
☐ Work release required
☐ on PROBATION for .....
☐ DRIVER'S LICENSE suspended .....
.....
☐ Referred to VASAP
☐ RESTITUTION of $.....
due by.....;
Payable to.....;
as condition of suspended sentence.
☐ ..... hours of community service to be performed for.....
.....
☐ in addition to other sentence provisions
☐ to be credited against fines and cost at $ ..... /hr.
☐ Bond: $.....
☐ Other:.....
.....
.....
☐ Appeal Bond $.....
☐ appeal noted on.....

BOND REFUNDED:
TO: Kyp Rep
AMT: $1,000
ID: notarized letter
DATE: 11/5/92
CK#: 5404
RELATED CASES: —
CLERK: ML
9/11/92

A COPY TESTE:
NANCY L. LAKE, CLERK
FAIRFAX COUNTY GENERAL DISTRICT COURT
BY: Marta Roberts
DEPUTY CLERK
Original returned to the Clerk's Office of the General District Court Fairfax County, Virginia

CASH BOND

☒ BY DEFENDANT
☐ BY THIRD PARTY

00 451 11/20/91 11:58 1 9158 3059217 1000

9-11-92
DATE

JUDGE D.J. SMITH
JUDGE

FINE	$ .....
126 LIQUIDATED DAMAGES	$ .....
COSTS	
112 / 140 PROCESSING FEE	$ .....
121 TIA FEE	.....
133 BLOOD TEST FEE	.....
132 CICF	.....
120 CT. APPT. ATTY.	.....
113 WITNESS FEE	.....
125 WEIGHING FEE	.....
OTHER (SPECIFY):	
.....	$ .....
TOTAL	$
109 INTEREST CHARGE	.....
TOTAL WITH INTEREST CHARGE	$

DATE PAID	RECEIPT NO.

Plea? _____ Yes ___X___ No Date _____

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

(Questions 23-25) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____Telephone _____

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

_____

_____

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer_____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

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

_____

_____

_____

_____

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

Your role (circle one):

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

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court _____

Court's location _____

Docket number _____

Date the action was filed _____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

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

Additional information, if any:

Vermont Department of Health - Board of Medical Practice
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 9/23/04

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

RECEIVED
OCT - 9 2008
Vermont Board of Medical Practice

License Number: 042-0010597

1. **Your legal name:**

Kym Margaret Boyman

a. Have you ever legally changed your name? X Yes ___ No

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

Last Name	First Name	Middle Name:	Suffix
Boyman	Kim	Margaret	

b. Indicate your name, as it should appear on your license:

Last Name	First Name	Middle Name:	Suffix
Boyman	Kym	Margaret	

2. **Your Date of Birth:** [redacted]

3. **Home 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):**

[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)
Maine	016345	Medical Practice	11/21/03	Active
New Hampshire	12128	Medical Practice	11/5/03	Active
~~None reported~~				

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
1999

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
2003

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1101	Ob/Gyn	☒ yes ☐ no	ABOG	2005	N/A (Not yet due to recertify)
		☐ yes ☐ no			

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

Month and year you started practicing as a physician? 2003

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

(2003-)

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.

Vermont Women's Choice
Staff Physician

Women's Health Care Service/Fletcher Allen Health Care
Burlington, VT
Attending Physician

University of Vermont
Burlington, VT
Director, Medical Student Clerkship

University of Vermont

Burlington, VT

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
~~Clinical Assistant~~ Clinical Assistant Professor
2003 to present

39. Publications: [26 VSA § 1368(a)(13)] ~~□ Check here if none~~ error ICS

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.

ACOG Vermont Junior Fellow Section Chair 2002

Gold Foundation Humanism and Excellence in Teaching Award 2002

AMWA Gender Equity Award 2003

Organon Resident Research Award for Outstanding Research in Women's Health 2003

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: 9/26/08 _____

_____
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 Fairfax County General District Court

City and State Fairfax, Virginia

Charge Obstruct Free Passage

Description Arrested for an act of civil disobedience 11/18/91

Status Charge dismissed 9/11/92

Conviction? ____ Yes X No Date ____

Plea? ____ Yes X 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:

_____

_____

_____

FAIRFAX COUNTY ☒ General District Court ☒ Criminal ☐ Traffic
☐ Juvenile and Domestic Relations District Court

December 13th , 1991 9:30 A.M.

4110 CHAIN BRIDGE ROAD FAIRFAX VA 2203

ACCUSED:
Boyman , Kym Margaret

[redacted]

COMPLETE DATA BELOW IF KNOWN

RACE	SEX	BORN MO DAY YR	HT FT	HT IN	WGT	EYES	HAIR
W	F	[redacted]	5	8	135	Haz	Bro

SS# [redacted]

Commonwealth of Virginia

WARRANT OF ARREST

CLASS One MISDEMEANOR

☒ EXECUTED by arresting the Accused named above on this day:

☐ EXECUTED by summoning the Accused named above on this day:

11-18-91
DATE AND TIME

O'HARA, P.J.
ARRESTING OFFICER

#1618 FFX. Co. P.D. 029
BADGE NO., AGENCY AND JURISDICTION

for _____
SHERIFF

Attorney for the Accused:
6P-11-P

Cor 8/5 50 Rpd 8/5

TO ANY AUTHORIZED OFFICER:

You are hereby commanded in the name of the Commonwealth of Virginia forthwith to arrest and bring the Accused before this Court to answer the charge that the Accused, within this city or county, on or about November 18th , 1991 (DATE) did unlawfully in violation of Section 18.2-404, Code of Virginia: Did unreasonably , and unnecessarily , obstruct the free passage of others :

check if applicable: ☐ commercial motor vehicle ☐ hazardous materials

I, the undersigned, have found probable cause to believe that the Accused committed the offense charged, based on the sworn statements of OfficerP.J.O'Hara EIN#1618 Fairfax County Police Dept. Complainant.

WARREN B. BROWN 003

Execution by summons ☐ permitted at officer's discretion XX not permitted.

about 7:15 A.M. November 18th , 1991
DATE AND TIME ISSUED

☐ CLERK ☒ MAGISTRATE ☐ JUDGE

A COPY TESTE:
NANCY L. LANE, CLERK
FAIRFAX COUNTY GENERAL DISTRICT COURT
BY: _____ DEPUTY CLERK
Original retained in the Clerk's Office of the General District Court of Fairfax County, Virginia

SUMMONS (If authorized above and by serving officer)

You are hereby commanded to appear before this court located at _____

on _____ at _____ AM/PM

I promise to appear in accordance with this Summons.

_____
ACCUSED

WARNING TO ACCUSED: You may be tried and convicted in your absence if you fail to appear in response to this Summons. Willful failure to appear is a separate offense. SIGNING THIS NOTICE DOES NOT CONSTITUTE AN ADMISSION OF GUILT.

FORM DC-314 6/90 (114:9-015 7/91)

Kym Boyman 0010597

☐ Motion to Change Bond on: .....
☐ changed to $.....
☐ no change

JUDGE

The Accused was this day:
☐ tried in absence
☐ present

Attorneys Present:

PROSECUTING ATTORNEY (NAME)

DEFENDANTS ATTORNEY (NAME)
☐ NO ATTORNEY
☐ ATTORNEY WAIVED

The Accused PLEADED:
☐ not guilty
☐ nolo contendere
☐ guilty

And was TRIED and FOUND by me:
☐ not guilty
☐ guilty as charged
☐ guilty of .....

And was FOUND by me to be:
☐ driving a commercial motor vehicle
☐ carrying hazardous materials

☒ I ORDER the charge dismissed
☒ I ORDER a nolle prosequi on Commonwealth's motion

DATE

☐ I impose the following Sentence: 91022778
☐ FINE of $..... with $..... suspended,
☐ JAIL sentence of ..... imposed with ..... suspended conditioned upon being of good behavior and keeping the peace.
☐ Serve jail sentence on weekend beginning .....
☐ Work release authorized if eligible
☐ Work release required
☐ on PROBATION for .....
☐ DRIVER'S LICENSE suspended .....
.....
☐ Referred to VASAP
☐ RESTITUTION of $.....
due by.....
Payable to.....
☐ as condition of suspended sentence.
☐ ..... hours of community service to be performed for.....
.....
☐ in addition to other sentence provisions
☐ to be credited against fines and cost
at $ ..... /hr.
☐ Bond: $.....
☐ Other:.....
.....

BOND REFUNDED:
TO: Kyp Rogers
AMT: $1000
ID: notarized letter
DATE: 11/5/92
CK#: 5464
RELATED CASES: —
CLERK: ML
9/11/92

Appeal Bond $.....
☐ appeal noted on.....

00 451 11/20/91 11:58 1 9158 3059217 1000

JUDGE D.J. SMITH

JUDGE

A COPY TESTE:
MARCIA L. LAKE, CLERK
FAIRFAX COUNTY GENERAL DISTRICT COURT
BY: Marcia Robertson
DEPUTY CLERK
Original retained in the Clerk's Office of the General District Court Fairfax County, Virginia

CASH BOND

☒ BY DEFENDANT
☐ BY THIRD PARTY

FINE	$ .....
126 LIQUIDATED DAMAGES	$ .....
COSTS	
112 / 140 PROCESSING FEE	$ .....
	.....
121 TIA FEE	.....
133 BLOOD TEST FEE	.....
132 CICF	.....
120 APPT. ATTY.	.....
113 WITNESS FEE	.....
125 WEIGHING FEE	.....
OTHER (SPECIFY):	
.....	$ .....
TOTAL	$
109 INTEREST CHARGE	.....
TOTAL WITH INTEREST CHARGE	$

DATE PAID	RECEIPT NO

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 9/26/08

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: 9/26/08 _____

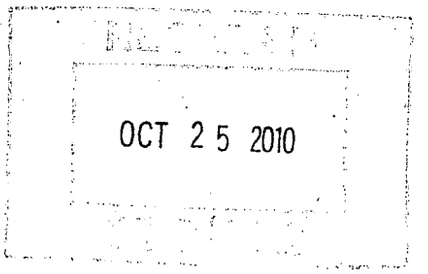
PLEASE NOTE:

In accordance with 4 V.S.A. § 1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

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

2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I



License Number: 042-0010597

1. **Your legal name:**

Kym Margaret Boyman

a. Have you ever legally changed your name? X Yes ___ No

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

Last Name	First Name	Middle Name:	Suffix
BOYMAN	KIM	MARGARET	

b. Indicate your name, as it should appear on your license:

Last Name	First Name	Middle Name:	Suffix
BOYMAN	KYM	MARGARET	

2. **Your Date of Birth:** 12/10/1966

3. **Mailing Address and email address:** [redacted]

4. **Work Address:**
23 Mansfield Avenue
BURLINGTON, VT 05401
[redacted]

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

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

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

8. **E-mail address (if not appearing in #3):** [redacted]

X
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 2003	016345	Medical practice	11/21/03	Active
NH 2003	12128	Medical practice	11/5/03	Active

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
1999

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
2003

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
2005, N/A

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? 2003

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)
Burlington, VT
(2003-Present)

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

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

☒ yes □ no

PART III

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

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

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

[redacted]

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

[redacted]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

[redacted]

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

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

[redacted]

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

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

[redacted]

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

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

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

None reported

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

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

None reported

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

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

None reported

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

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

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.

Vermont Women's Choice
Staff Physician

Women's Health Care Service/Fletcher Allen Health Care

Burlington, VT
Attending Physician

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
Clinical Assistant Professor
2003 - 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.

ACOG Vermont Junior Fellow Section Chair 2002

Gold Foundation Humanism and Excellence in Teaching Award 2002

AMWA Gender Equity Award 2003

Organon Resident Research Award for Outstanding Research in Women's Health 2003

Add: FAHC ob/gyn Chief Resident Teaching Award 2004-2008

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: 10/17/10

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 → Previously provided on prior applications See attached

Court Fairfax County General District Court

City and State Fairfax, Virginia

Charge Obstruct Free Passage

Description Arrested for an act of civil disobedience

11/18/91

Status Charge dismissed 9/11/92

Conviction? ____ Yes ___X___ No Date ____

Plea? ____ Yes ___X___ 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 ____

FAIRFAX COUNTY ☐ General District Court ☒ Criminal ☐ Traffic ☐ Juvenile and Domestic Relations District Court

December 13th , 1991 9:30 A.M.

4110 CHAIN BRIDGE ROAD FAIRFAX VA 220

ACCUSED:

Boyman , Kym Margaret

[redacted]

COMPLETE DATA BELOW IF KNOWN

RACE	SEX	BORN MO. DAY YR.	HT FT.	HT IN.	WGT	EYES	HAIR
W	F	[redacted]	5	8	135	Haz	Bro

SSN [redacted]

TO ANY AUTHORIZED OFFICER:

You are hereby commanded in the name of the Commonwealth of Virginia forthwith to arrest and bring the Accused before this Court to answer the charge that the Accused, within this city or county, on or about November 18th , 1991 (DATE) did unlawfully in violation of Section 18.2-404, Code of Virginia:

Did unreasonably , and unnecessarily , obstruct the free passage of others :

check if applicable: ☐ commercial motor vehicle ☐ hazardous materials

I, the undersigned, have found probable cause to believe that the Accused committed the offense charged, based on the sworn statements of OfficerP.J.O'Hara EIN#1618 Fairfax County Police Dept. Complainant.

Execution by summons ☐ permitted at officer's discretion XX not permitted.

about 7:15 A.M. November 18th , 1991 (DATE AND TIME ISSUED)

WARREN B. BROWN 003

☐ CLERK ☒ MAGISTRATE ☐ JUDGE

A COPY TESTE:
NANCY L. LAKE, CLERK
FAIRFAX COUNTY GENERAL DISTRICT COURT
BY: DEPUTY CLERK
Original retained in the Clerk's Office of the General District Court of Fairfax County, Virginia

SUMMONS (If authorized above and by serving officer)

You are hereby commanded to appear before this court located at .....

on ..... at ..... AM/PM

I promise to appear in accordance with this Summons.

ACCUSED

WARNING TO ACCUSED: You may be tried and convicted in your absence if you fail to appear in response to this Summons. Willful failure to appear is a separate offense. SIGNING THIS NOTICE DOES NOT CONSTITUTE AN ADMISSION OF GUILT.

FORM DC-314 6/90 (114:9-015 7/91)

Commonwealth of Virginia

WARRANT OF ARREST

CLASS One MISDEMEANOR

☒ EXECUTED by arresting the Accused named above on this day:

☐ EXECUTED by summoning the Accused named above on this day:

11-18-91 (DATE AND TIME)

O'HARA , P. J. (ARRESTING OFFICER)

#1618 FFX. Co. P.D. 029 (BADGE NO., AGENCY AND JURISDICTION)

for ..... SHERIFF

Attorney for the Accused:

6P-11-P

Con 8/5 50 hrs c/s 10/92

Kym Boyman 042-0010597

☐ Motion to Change Bond on: .....
☐ changed to $ .....
☐ no change

JUDGE

The Accused was this day:
☐ tried in absence
☐ present

Attorneys Present:

PROSECUTING ATTORNEY (NAME)

DEFENDANT'S ATTORNEY (NAME)
☐ NO ATTORNEY
☐ ATTORNEY WAIVED

The Accused PLEADED:
☐ not guilty
☐ nolo contendere
☐ guilty

And was TRIED and FOUND by me:
☐ not guilty
☐ guilty as charged
☐ guilty of .....

And was FOUND by me to be:
☐ driving a commercial motor vehicle
☐ carrying hazardous materials

☒ I ORDER the charge dismissed
☒ I ORDER a nolle prosequi on Commonwealth's motion

9/11/92

9-11-92
DATE

☐ I impose the following Sentence: 91022778
☐ FINE of $..... with $..... suspended;
☐ JAIL sentence of ..... imposed with ..... suspended conditioned upon being of good behavior and keeping the peace.
☐ Serve jail sentence on weekend beginning .....
☐ Work release authorized if eligible
☐ Work release required
☐ on PROBATION for .....
☐ DRIVER'S LICENSE suspended .....
.....
☐ Referred to VASAP
☐ RESTITUTION of $.....
due by.....;
Payable to.....;
as condition of suspended sentence.
☐ ..... hours of community service to be performed for.....
.....
☐ in addition to other sentence provisions
☐ to be credited against fines and cost at $ ..... /hr.
☐ Bond: $.....
☐ Other:.....
.....
.....
☐ Appeal Bond $.....
☐ appeal noted on.....

JUDGE D.J. SMITH

BOND REFUNDED:
TO: Kyp Rep
AMT: $1000
ID: notarized letter
DATE: 11/5/92
CK#: 5464
RELATED CASES: —
CLERK: ML

00 451 11/20/91 11:58 1 9158 3059217 $100

A COPY TESTE:
NANCY G. LAKE, CLERK
FAIRFAX COUNTY GENERAL
DISTRICT COURT
BY: Wanda Roberts
DEPUTY CLERK
Original returned to the Clerk's Office
of the General District Court
Fairfax County, Virginia

CASH BOND

☒ BY DEFENDANT
☐ BY THIRD PARTY

FINE	$ .....
126 LIQUIDATED DAMAGES	$ .....
COSTS	
112 / 140 PROCESSING FEE	$ .....
121 TIA FEE	.....
133 BLOOD TEST FEE	.....
132 CICF	.....
120 CT. APPT. ATTY.	.....
113 WITNESS FEE	.....
125 WEIGHING FEE	.....
OTHER (SPECIFY):	
.....	$ .....
TOTAL	$
109 INTEREST CHARGE	.....
TOTAL WITH INTEREST CHARGE	$

DATE PAID	RECEIPT NO

(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: 10/7/10

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.

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 10/17/10

Renewal - 042.0010597

Name	Kym Margaret Boyman
Credential	042.0010597

Fee Details

	$500.00
	$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@vdh.state.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

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

Be sure to submit:

- completed application
- completed Form A
- completed *Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions*, whether or not you have children.
- any other attachments
- payment in the amount of $500 to the **Vermont Department of Health**
- ***LATE FEE:*** Applications received after the license expiration date will be assessed a $25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:
Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you

must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
Boyman

2. First Name:
Kym

3. Middle Name:
Margaret

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
Kim Boyman	December	1966	January	1990	Changed my name from Kim to Kym as a young adult.

6. Date of Birth:
[redacted]

7. Enter your MAILING ADDRESS information:

Attention Kym Boyman
Street [redacted]
City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States
E-mail Address [redacted]
Telephone [redacted] **Alternate Phone (e.g. Pager)** [redacted]

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
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
New Hampshire	MD	12128	11/05/2003	06/30/2011	Not Renewed
Maine	MD	016345	11/21/2003	04/22/2011	Not Renewed

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

13. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]
Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Fletcher Allen Health Care	06/23/2003	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	11/11/2005	

15. **Years of Practice**
What year did you start practicing as a medical professional?
2003

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	08/01/2003

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?
Yes

23. State:
New Hampshire

24. Year:
2011

25. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:
Chose not to renew NH and ME medical licenses due to not practicing medicine in those states (licensure in NH and ME was required for my prior job). I currently practice only in Vermont, so am licensed only in Vermont.

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	Clinical Assistant Professor	1999	

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	Burlington	Vermont	Ob/Gyn Clerkship Director	2003	2005

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

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
UVM/FAHC Chief Resident Award for Excellence in Teaching (2005-2009)
Organon Resident Research Award for Outstanding Research in Women's Health (2003)
American Medical Women's Association Clinical Gender Equity Award (2003)
Teaching Chief Resident, UVM Department of Ob/Gyn (2002-2003)
The Gold Foundation Humanism and Excellence in Teaching Award (2002)
Berlex Best Teaching Resident (2001)
University of Vermont College of Medicine Humanism in Medicine Award (1999)
The Carbee Award for Excellence in Obstetrics and Gynecology (1999)

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?
Vermont Gynecology	South 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:
09/07/2012

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:

09/07/2012

Renewal Payment

127. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.

Self / Credit Card

Review

Renewal - 042.0010597

Name	Kym Margaret Boyman
Credential	042.0010597

Fee Details

Renewal	$500.00
	$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4223, 800-745-7371 or medicalboard@state.vt.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.
- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to Malpractice

Malpractice Claim Documentation – If you have reportable malpractice history, you must download Form A, carefully complete a form for each case, and submit it along with the required documentation. For your application, reportable malpractice includes:

- Pending claims that have not been resolved.
- Cases that resulted in a payment by you or on your behalf, whether as a settlement, arbitration award, or court verdict.
- Note that you need not report cases that were resolved in your favor with no payment by you or on your behalf. This includes cases that were withdrawn without payment, dismissed without payment, or resolved by a verdict in your favor.

Be sure to submit:
- completed Form A, if applicable
- payment in the amount of $500 to the **Vermont Department of Health**
- ***LATE FEE:*** Applications received after the license expiration date will be assessed a $25 late fee.

Please Note:
- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:
Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you

must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
   Boyman

2. First Name:
   Kym

3. Middle Name:
   Margaret

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
Kim Boyman	December	1966	January	1990	Changed my name from Kim to Kym as a young adult.

6. Date of Birth:
   [redacted]

7. Please provide your preferred email address for receiving important correspondence from this medical board
   kboyman@mac.com

8. Enter your MAILING ADDRESS information:

Attention Kym Boyman
Street [redacted]
City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States
E-mail Address [redacted]
Telephone [redacted] **Alternate Phone (e.g. Pager)** [redacted]

9. Enter your PUBLIC ACCESS address information:

Attention
Street 1775 Williston Rd., Suite 110
City SOUTH BURLINGTON **State** VT **Zip** 05403
Country United States
Telephone
E-mail Address
Alternate Phone (e.g. Pager)

Renewal Part II

10. Were you in active clinical practice in the past 12 months?
    Yes

11. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state?
    Yes

12. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Maine	MD	016345	11/21/2003	04/22/2011	Not Renewed

New Hampshire	MD	12128	11/05/2003	06/30/2011	Not Renewed

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**:	05/30/1999

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	06/23/2003	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	11/11/2005	

16. **Years of Practice**
What year did you start practicing as a medical professional?
2003

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	08/01/2003	

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.
[redacted]

75. Jurisdiction:

76. Description of matter under Investigation:

77. Date you became aware of Investigation:

78. Upload any documents you may have relating to the matter under investigation:

79. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and a description of the matter under investigation in the following questions and upload relevant documents where indicated.

80. Licensing or certification board conducting investigation:

81. Date of event(s) under investigation:

82. Nature of event(s) under investigation:

83. Pending licensing board investigation – upload documents.

MEDICAL DEFINITIONS

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

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

87. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to

practice medicine in your field of practice with reasonable skill and safety?

[redacted]

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

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

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

[redacted]

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

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

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

93. Treating organization:

94. Address:

95. Telephone:

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

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

98. Dates of treatment (from, to):

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

100. Address:

101. Telephone:

102. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

Applicants with other events or actions that must be reported (e.g., a criminal conviction) must provide documentation of each event. It is very important for the Board to receive copies of court papers, licensing authority decisions, or similar documentation, as noted below. The Board will not act on an application that lacks required documentation**. If any reportable event involves alcohol or drugs in any way, you must contact the Vermont Practitioner Health Program to arrange for an evaluation**. **The Board will not act on an application that is missing a required evaluation.** You may contact VPHP at (802) 223-0400. Information about VPHP is online at: **http://www.vtmd.org/health-professional-wellness-and-recovery-programs**.

103. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crime? This includes both misdemeanors and felonies; it includes crimes such as driving under the influence (DUI), but not non-criminal traffic offenses such as speeding or parking tickets. For purposes of this question, "convicted" means that you pleaded guilty or were adjudged guilty by a court of competent jurisdiction. For this question, it also includes the loss of a driver's license as a result of a civil process triggered by the refusal to provide a sample of breath for the purpose of screening for driving while under the influence of alcohol.

No

104. **Criminal Convictions continued** [See 26 VSA § 1368(a)(1)] Provide information regarding each conviction as defined above. **In addition to entering the information here, you must submit copies of documents that show information about the crime (s) of which you were convicted and the sentence imposed, to include the police report, any ticket/citation/indictment/arrest record, and final disposition.**

Date of Conviction	Court of Conviction	City	State	Description

105. Nolo Contendere/Matters [See 26 VSA § 1368(a)(2)]
Have you ever had a criminal involvement that resulted in a case resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

106. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Provide information regarding each criminal involvement resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges

107. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

108. Vermont Board of Medical Practice Matters continued [See 26 VSA § 1368(a)(3)]
Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date	Final Disposition Summary

109. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

110. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

111. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?

No

112.
A. Revocation or Restriction of Hospital Privileges Information
Provide information about each instance in which hospital privileges were revoked or involuntarily restricted for reasons related to competence or character. Provide documentation that shows the date, basis for the action, the authority who took the action, and the action taken.

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

113. Have you ever, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character, done any of the following:

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?
No

114. B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information
Provide information about each instance in which you resigned or did not renew medical staff membership, or you had hospital privileges restricted, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character? Provide documentation that shows the date, the hospital, the basis for and nature of the case, and the terms of settlement, if any.

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

115. Medical Malpractice Court Judgments & Settlements Have you ever had a medical malpractice claim against you that is still pending or that resulted in any of the following:

- a court judgment against you; or

- an arbitration award or a settlement that you or another party paid on your behalf?

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located **here** Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.
No

116. **A. Judgments**
Provide the information requested in the following table for each case in which there was a court judgment or arbitration award against you.

Date of Judgment	Number of Judgments

117. **B. Settlements**
Provide the information requested in the following table for each case in which you were named as a defendant and in which a settlement was paid by you or on your behalf.

Date Of Settlement

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

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	Assistant Clinical Professor	2003	

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
UVM/FAHC Chief Resident Award for Excellence in Teaching (2005-2009)
Organon Resident Research Award for Outstanding Research in Women's Health (2003)
American Medical Women's Association Clinical Gender Equity Award (2003)
Teaching Chief Resident, UVM Department of Ob/Gyn (2002-2003)
The Gold Foundation Humanism and Excellence in Teaching Award (2002)
Berlex Best Teaching Resident (2001)
University of Vermont College of Medicine Humanism in Medicine Award (1999)
The Carbee Award for Excellence in Obstetrics and Gynecology (1999)

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	South 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:
10/10/2014

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

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

126. You must select one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

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

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

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

128. Social Security Number:
[redacted]

129. Date of Birth:
[redacted]

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

131. Date:
10/10/2014

Continuing Medical Education Requirements

Each applicant for renewal must certify that he or she meets the requirements for CME as indicated by one of the statements below, a – f. Note that for purposes of this certification, completion of an activity includes taking the steps necessary to receive credit and obtain documentation of completion. If you cannot certify that you are eligible to renew your license because one of the statements applies to you, then you must contact the Board of Medical Practice to discuss your renewal application. You are not required to submit documentation of your CME activities with your renewal application, but licensees are subject to audit and may be asked to submit such documentation during the next two licensing cycles (for this renewal, through November 30, 2018).

The Rules for Continuing Medical Education are available on the Board's website at:
http://healthvermont.gov/hc/med_board/documents/FinalCMERules10.1.12_000.pdf

a) I do not have to complete CME for this renewal because I was licensed as an MD in Vermont for the first time on or after December 1, 2013.

b) I was licensed as an MD for the first time in Vermont between December 1, 2012 and November 30, 2013. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

c) I have completed at least 30 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances.

d) I am a member of the armed forces of the United States and I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) one year or more. Accordingly, I am not required to certify that I completed CME for this renewal.

e) I am a member of the armed forces of the United States and during the period from June 1, 2012 to November 30, 2014, I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) less than one year. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

f) I have not completed the required CME for renewal, but I have submitted a make-up plan that I have signed and that was approved by the Executive Director of the Board.

132. I hereby certify that I have satisfied the Vermont Board of Medical Practice requirements for CME as indicated in the above statement. Select the one that best applies.
C

Workforce Survey

“Since 1999, the State of Vermont has been conducting a census of some professions every two years as part of relicensing. This has allowed us to monitor changes in Vermont’s health care workforce. In 2012, the Legislature enacted a law to make work force data collection mandatory for all health care professions at license renewal as a necessary part of health care reform and planning for our health care future. We would like to thank you for your participation in this census.”

You must complete the workforce survey before you may complete your application to renew your license. The mandatory workforce survey is accessed by clicking **here**

133. I hereby certify that I have completed the workforce survey per the above instructions
Yes

Renewal Payment

134. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.
Credit Card

Review

Hayes, Tracy

From: Green, Julie on behalf of medicalboard
Sent: Wednesday, December 22, 2010 7:39 AM
To: Hayes, Tracy
Subject: FW: change of practice address

Vermont Board of Medical Practice
108 Cherry Street
P.O. Box 70
Burlington, VT 05402
(*physical address: 101 Cherry Street 3rd Floor*)

-----Original Message-----
From: Kym Boyman [mailto:[redacted]
Sent: Tuesday, December 21, 2010 2:49 PM
To: medicalboard
Cc: Boyman Kym
Subject: change of practice address

Hello,

Please note my change of address for my medical license:

Kym Margaret Boyman, MD
1775 Williston Rd., Suite 110
South Burlington, VT 05403

License # 042-0010597 effective 10/26/10

The new practice, if you need it for your records, is Vermont Gynecology, P.C.
The new practice phone # is 802-428-4663

Please send me a new license -- as well as any other mail -- to my home address:

[redacted]

I understand there is a $10 fee to print the new license. Can you send me a bill for that? Please send instructions.

I also need to submit a change of address for the DEA. They say "***Do not submit*** *this until you have an approved state license for the new address.*" How soon will that be? Is it something they verify electronically?

Thanks,

Kym Boyman, MD

[redacted]

Vermont Department of Health
Board of Medical Practice

Agency of Human Services

June 4, 2003

Kym Boyman, MD
1391 Robinson Road
Ferrisburgh, VT 05456

Re: Vermont Medical Licensure
42-0010597

Dear Dr. Boyman:

Congratulations! On June 4, 2003, by unanimous vote of the Vermont Board of Medical Practice, you were granted a Vermont medical license. Please note your license number indicated above.

Your registration card is enclosed and a wall certificate has been ordered and will be sent to you under separate cover. **All medical licenses must be renewed by November 30, 2004.** You will receive a notification two months prior to renewal.

Please let us know if you have any questions or concerns.

Sincerely,

Tracy

Tracy Hayes
Administrative Assistant

Please Note: It is your responsibility to notify this office of any change of address.

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

Agency of Human Services

April 29, 2003

Kym Boyman, MD
[redacted]

Dear Dr Boyman:

Your application for medical licensure appears to be complete. It now becomes your responsibility to contact the Board member listed below to arrange for your personal interview:

Please call after 9:00 a.m.

Dewees H. Brown, M.D.
[redacted]

You must complete your interview within six months from the date of this letter or your application will be considered stale. This means that you will have to update the following: License verifications from other states; three letters of recommendation; National Practitioners Data Bank Self Query, and the AMA Profile.

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

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

Sincerely,

Tracy Hayes

Tracy Hayes
Administrative Assistant

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

Agency of Human Services

April 29, 2003

Dewees H. Brown, M.D.
[redacted]

Dear Dr Brown:

The application for medical licensure for **Kym Boyman, M.D.,** appears complete, and is enclosed for your review. The applicant will be calling you to schedule a personal interview. Following the interview, you may present the application at the first, regularly scheduled Board meeting.

Should you have any questions or concerns, please let me know.

Sincerely,

Tracy Hayes

Tracy Hayes
Administrative Assistant

Enclosures

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

Medical Doctor Application Checklist
For Office Use Only
STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

Name of Applicant: Kym Margaret Boyman
Address: [redacted]

Telephone: [redacted]

Date Application Received: 4/28/03

____**US Graduate** ____**Canadian Graduate** ____**International Graduate**
(Unless noted, a copy of original, and English translation if applicable, is required to be submitted):

1) Y **FEE of $400.00**

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

Y **Photograph Applicant's signature required on photograph.**
Y **Tax & Child Support Statement Applicant's signature required.**
X **Form B: Release Applicant's signature required.**

*3) X **BIRTH CERTIFICATE - Notarized**
Date of Birth: [redacted] Place of Birth: St. Louis, Missouri

*4) Y **MEDICAL SCHOOL DIPLOMA - Notarized**
UVM Date: 5/23/1999

*5) Y **"MEDICAL EDUCATION CERTIFICATE"- Direct Verification**

*6) X **"MEDICAL LICENSURE CERTIFICATE" - Direct Verification**
☒ **All in good standing**
X VT LTC ___ _____
___ _____ ___ _____
___ _____ ___ _____

*7) X **EXAMINATION SCORES: Direct Verification of Examination Scores:**

X **USMLE**** _____ **FLEX** _____ **National Boards** _____ **State Exam**

1 Number of times applicant has taken USMLE Step 3 (can be no more than 3 times).
___Number of years applicant has taken to complete (can be no more than 7 times)

*8) N/A **AMERICAN SPECIALTY BOARD CERTIFICATE, if applicable - Notarized**
OB/GYN

*9) X **POSTGRADUATE TRAINING** from an ACGME approved residency program - **Direct Verification**. "VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION" must be completed by Program Director.

UVM _____ DATES _____ ACGME _____

_____ DATES _____ ACGME _____

_____ DATES _____ ACGME _____

10) X **Three (3) COMPLETED REFERENCE FORMS** mailed directly to the Board by the Chief of Service and two other active physician staff members at the hospital where the applicant has a current or recent appointment. Program Director should be substituted for Chief of Service for applicants who are applying for license while still in residency training or have completed a residency within the last year.

____ **#1** Chief of Service _____

or X Program Director Cheung Leong, MD

X **#2** Active Physician Staff Member Diane Granland, MD

X **#3** Active Physician Staff Member Julia Brock, MD

11) X **American Medical Association Profile Form.**

❑ Verify information provided on application

*12) PA **ECFMG Certificate, if International Graduate.** ____ **Verification of Fifth Pathway**

❑ Passed/Approved

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

❑ Has applicant included everything on the application

14) PA **FORM A if applicant answered "Yes" in Section III—Refer to licensing Committee**

15) X **FEDERATION CHECK**

❑ Check for board actions

* **NOTE**: FCVS Acceptance - The Board accepts certain documents noted by asterisks (*) above.

PGW

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

108 Cherry Street, PO Box 70
Burlington VT 05402-0070

APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT
PHYSICIAN - MEDICAL DOCTOR

I hereby apply for LICENSURE AS A PHYSICIAN in the state of Vermont.

Instructions

- *Please enclose a check in the amount of $400 payable to the Vermont Department of Health.*
- *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.*
- *Use the enclosed Form A to provide explanations to "yes" answers in Parts III and IV.*
- *Please be sure to write your name 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 findings of unprofessional conduct.*

Part I - Identity Questions

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

First name: KYM

Middle name: MARGARET

Last name: BOYMAN

Extension:

RECEIVED
APR 28 2003
VERMONT BOARD OF MEDICAL PRACTICE

2. Have you ever legally changed your name? [X] Yes [ ] No
If yes, enclose a certified copy of the legal document stating the change.

*Name as it should appear on your license: Kym Margaret Boyman

Other Name(s), if any, under which you were licensed elsewhere: _____

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: [redacted]

Town/City:

State: [redacted]

Zip Code: [redacted]

5. Your electronic addresses:

Home telephone (optional): [redacted] example: 802-555-1212

Work telephone: 802-847-1000 x 0379

E-mail (optional): [redacted]

6. Were you in active practice in Vermont in the past 12 Months? [X] Yes [ ] No (as a Resident)

7. Have you ever held a Vermont Limited Temporary License? [X] Yes [ ] No
If yes, License Number 060-0002585

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

If yes, complete the section below:

State	License Number	Date Issued M M D D Y Y Y Y	Status (Active, inactive, other)

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

Part II – Education, Training, Practice and Examinations

9. Premedical Education

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

Name and location of institution	Degree	From	To
Stanford University: Palo Alto, California	A.B. History	9/85	6/89
Foothill College: Los Altos, CA	None	6/89	8/89
Montgomery College: Rockville, MD	None	6/92	12/92
Middlebury College: Middlebury, VT	None	2/93	5/94
Univ. of Vermont: Burlington, VT	None	5/93	7/93

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

10. Medical Professional Schools - See enclosed Certificate of Medical Education

Please provide the names of medical professional schools you attended and the dates of attendance. ***Note: This information should be provided in the Statutory Profile Section (Part V #36)*** University of Vermont College of Medicine 8/95 - 5/99

11. Graduate Medical Education University of Vermont 6/99 - 6/03

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

Note: This information should be provided in the Statutory Profile Section (Part V #37)

12. Examinations

A. USMLE or FLEX Examination
Have you ever taken the USMLE or FLEX examination? ☒ **Yes** ☐ **No**
If yes, have a Certified Copy of your results forwarded to this office by the Federation of State Medical Board.

B. National Boards
Have you ever taken the National Boards? ☐ **Yes** ☒ **No**
If yes, have a Certified Copy of your results forwarded to this office by the National Board of Medical Examiners.

C. State Examination
Have you ever taken a State Medical Board Examination? ☐ **Yes** ☒ **No**
If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board (see enclosed Certificate of Medical Licensure).

13. International Medical Graduates N/A

*boxes

A. ECFMG Standard Certificate Number: _____ Date issued: _____

B. Direct verification of your ECFMG Certificate must accompany this application. (See enclosed request form)

C. Are you a graduate of a fifth pathway program: ☐ **Yes** ☐ **No**
If yes, direct verification of your fifth pathway certificate must accompany this application.

14. Practice

*Do you have hospital privileges? ____ Yes __X__ No (Not yet)

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

Name	**Address**	**From/To**	**Specialty/Subspecialty**

Part III - Licensure and Practice Questions

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

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

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

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

18. Are any formal disciplinary charges pending against you by any governmental authority, hospital or health care facility, or professional medical association?

☐ **Yes** ☒ **No**

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

☐ **Yes** ☒ **No**

20. 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**

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

☐ **Yes** ☒ **No**

22. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted?

☐ **Yes** ☒ **No**

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

☐ **Yes** ☒ **No**

24. To your knowledge, are you presently named in a malpractice action that has **not** been resolved (i.e., has **not** been either dismissed or settled)?

☐ **Yes** ☒ **No**

Part IV - Confidential Section

Part IV is exempt from public disclosure

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

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

[redacted]

26. 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.

27. 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 treatment and monitoring program.

28. 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 rehabilitation and monitoring program.

29. 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 802-223-0400 (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 V - 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 answer the following questions to the best of your ability. 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.

30. **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: .....

31. **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: .....

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

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

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

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

33. **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: .....

34. **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: .....

35. **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: .....

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

Please provide the name, location, dates of attendance of medical schools attended.

School	City	State	Year of Graduation
Univ. of VT College of Medicine	Burlington	VT	1999

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

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

List chronologically residency or other graduate training. Give names, addresses of hospitals, dates (month, day, year) and type of training. Include copies of Certificate of Attendance.

*Name Address Fron/To Training

School/Institution	Specialty	City	State	Year of Graduation
Univ. of VT / FAHC	Ob/Gyn	Burlington	VT	2003

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

38. **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	Obstetrics & Gynecology	yes (no)	ABOG		
		yes no			
		yes no			

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

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

M	M	Y	Y	Y	Y

B.. List all hospitals where you previously have had staff privileges. Include name, address and include dated.

*Name Address Fron/To Specialty/SubSpecialty

Name	City	State		Year Started			

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

40. **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	pending			

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

41. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #41 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)
University of Vermont	Burlington	V	T	Clinical Instructor 06/bgn	6/99	6/03

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

B. Teaching

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

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

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

42. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #42 is optional. By answering, you are granting permission to have this information posted on the web.

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

Title	Publication	Year

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

43. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #43 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
The Carbee Award for Excellence in Obstetrics / Gynecology ('99)
Healthcare Foundation of New Jersey Humanism in Medicine Award ('99)
The Gold Foundation Humanism and Excellence in Teaching Award ('02)

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

ACOG Vermont Chapter Jr. Fellow Vice-chair ('01) & Chair ('02)

End of Statutory Profile Questions

---

44. **Interview**

A. In which part of Vermont would you prefer to be interviewed? (Northern - Burlington area, Southern - Springfield or Rutland areas, Central - Montpelier area)

Northern

B. When are you scheduled to begin work in Vermont? August 2003

C. What has been your physical residence (city, state) in the past ten years? [redacted]

Part VI - Photograph

PLEASE PROVIDE A PHOTOGRAPH: Attach a recent photograph (head and shoulders). Please sign the front of the photograph.

PHOTOGRAPH

Part VII - Signature

Reminder - You must also complete and sign the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions, Form B, and authorizations for release of information as appropriate, Form C..

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: 4/21/03

Applicant's Signature

Return completed application to:

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 2/15/03

FORM B

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

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

1) I, Kym Boyman (Name of Applicant), HEREBY AUTHORIZE YOU to furnish to the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my education, my professional experience and qualifications, my licensing history, my practice as a physician, civil and criminal court records, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for licensure.

Signature: KBoyman

Date: 2/15/03

Print or Type Name: Kym Boyman

Address: [redacted]

City, State, Zip Code: [redacted]

Telephone Number: [redacted]

Subscribed and sworn to before me, this 15 day of February 2003

Amy R Rugg
Notary Public

Affix Seal

My License Expires: 2/10/2007

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

The College of Medicine
of
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

Kym Margaret Boyman, A.B.

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 twenty-third day of May in the year of our Lord, One Thousand Nine Hundred and Ninety-Nine and of the University the Two Hundred and Eighth.

Barbarah Grimes
Secretary of the Board of Trustees

Judith A. Ramaley
President of the University

Dean

Maya Susan Sproul, M.D.
Associate Dean for Student Affairs

Certified as a true and exact copy of original document.

RECEIVED
FEB 10 2003
2/6/03
VERMONT BOARD OF MEDICAL PRACTICE

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

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an officer of your School of Medicine

I hereby certify that Kym. M. Boyman (Name) was admitted to the

University of Vermont College of Medicine School of Medicine

in Burlington, VT (City and State) on 8/15/95 (Date)

and completed all requirements for graduation on 4/30/99 (Date).

A Doctor of Medicine (Specify certificate/diploma/degree) was granted on 5/23/1999 (Date).

(AFFIX SEAL)

Date: 2/6/03

Signed: Marga Susan Sproul
(Authorized Officer of the School) Marga Susan Sproul, M.D.
Associate Dean for Student Affairs

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

USMLE United States Medical Licensing Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 02/04/2003

Copy: 2

Vermont Board of Medical Practice
ATTN: Gloria Hurd, Exec Director
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070

Examinee: Boyman, Kym
USMLE ID#: 5-028-747-3
DOB: [redacted]
Alt Name(s): Boyman, Kym Margaret

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/9/1998	PASS	197	(179)	81	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	8/25/1998	PASS	206	(170)	83	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
VERMONT	7/27/2000	PASS	204	(177)	83	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

RECEIVED
FEB 7 2003
VERMONT BOARD OF MEDICAL PRACTICE

Patent 5636874

TamperSafe Patent #5,772,249

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

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: University of Vermont/Fletcher Allen Health Care

Address: 111 Colchester Avenue

Burlington, VT 05401

If name of the Institution was different when applicant attended, please enter name: _____

I hereby certify that Kym Boyman (Name) was enrolled in the

OB/GYN Residency
Program Type (residency, fellowship)

OB/GYN
Department (e.g. Radiology, Internal Medicine)

at this institution from 06 (Month) / 23 (Day) / 1999 (Year) to

06 (Month) / 22 (Day) / 2003 (Year).

During the time of the applicant's participation, our postgraduate medical training was accredited by the ACGME. If Canadian Training circle if approved by Royal College of Physicians and Surgeons of Canada.

Our records indicate that the applicant will receive a certificate of completion on

06 (Month) / 22 (Day) / 03 (Year).

(AFFIX SEAL)

Date: 3/14/03

Signed: _____
(Official of the Sponsoring Institution)

Print Name: Marjorie C. Meyer, M.D.

Title: OB/GYN Residency Program Director

Lynn Boyman, MD

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

LIST OF THREE REFERENCES

Detach the attached Reference Forms and send to the individuals designated below* ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

***NOTE: Program Director should be substituted** for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year. **(SEE ATTACHED SEPARATE FORM FOR PROGRAM DIRECTOR.)**

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): Cheung Wong, MD

Address: Department of Ob/Gyn, FAHC - MCHV Campus
111 Colchester Ave, Burgess 2, Burlington, VT 05401

City, State, Zip Code: _____

Telephone: (802) 847-5110

How long and in what capacity has this individual known you? ~3yrs - As faculty MD + Program Director

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

Name: Diane Charland, MD

Address: Department of Ob/Gyn, FAHC - MCHV Campus
111 Colchester Ave, Burgess 2

City, State, Zip Code: Burlington, VT 05401

Telephone: (802) 847-1600

How long and in what capacity has this individual known you? ~3yrs - As faculty, MD

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

Name: Julia Brock, MD

Address: 76 Colchester Ave.

City, State, Zip Code: Burlington, VT 05401

Telephone: (802) 862-7338

How long and in what capacity has this individual known you? ~7yrs - As Co-Medical Students & Ob/Gyn residents, and as faculty

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

Program Director Form
Return Directly to Board

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

EVALUATION FORM TO BE COMPLETED BY PROGRAM DIRECTOR, PAGE ONE OF THREE

Name of Applicant: Kym Bayman

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

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

Dr. Kym Bayman was at OB/GyN Resident

from 7/1999 to 6/2003. During that time, he/she was

(List status in the institution): Fahnestock Allen Health Care

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

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

Program Director Form
Continued

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

EVALUATION FORM TO BE COMPLETED BY PROGRAM DIRECTOR, PAGE TWO OF THREE

Name of Applicant: Kym Boyman
How long have you known the applicant? 3½ yrs.

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ✓ Yes ___ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ___ Yes ✓ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ___ Yes ✓ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is **not** minor.) ___ Yes ✓ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ___ Yes ✓ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ___ Yes ✓ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___ Yes ✓ No

Do you know of a failure of the applicant to complete a residency training program(s)? ___ Yes ✓ No

Does the applicant call upon consults when needed? ___ Yes ✓ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education? ___ Yes ✓ No

Was the applicant ever placed on probation or otherwise formally disciplined? ___ Yes ✓ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence? ___ Yes ✓ No

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

Program Director Form
Continued

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

EVALUATION FORM TO BE COMPLETED BY PROGRAM DIRECTOR, PAGE THREE OF THREE

Name of Applicant: Kym Boyman

The above report is based on:
- ✓ Close personal observation
- ____ General impression
- ____ A composite of previous evaluations
- ____ Other - Specify: ____

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

I recommend Kym Boyman for licensure in Vermont.
Name of Physician

Signed: Cheung Wong Date: 3/12/03

Print or Type Name and Title: CHEUNG WONG, MD.
Associate Program Director of OB/Gyn
Fletcher Allen Health Care

Kym Boyman, MD

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

RESIDENCY EVALUATION FORM TO BE SUBMITTED TO THE BOARD IF YOU ARE STILL IN RESIDENCY TRAINING OR HAVE COMPLETED A RESIDENCY WITHIN THE LAST YEAR

Detach the attached Evaluation Form and send it to your Program Director ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. The Program Director completing the evaluation form must return the form directly to the Board.

Name, address and telephone number of your Program Director:

1) Name of Program Director: Cheung Wing, MD

Address: Department of Ob/Gyn

Fletcher Allen Health Care, MCHV campus

111 Colchester Ave, Burgess 2

City, State, Zip Code: Burlington, VT 05401

Telephone: (802) 847-5110

Reference Form #2
Return Directly to Board

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

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE ONE OF TWO

Name of Applicant: Kym Boyman

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

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

Dr. KYM BOYMAN was at FLETCHER ALLEN HEALTH CARE

from 1999 to 2003 / PRESENT. During that time, he/she was

(List status in the Institution): RESIDENT OB/GYN

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

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

Reference Form #2
Continued

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

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: Kym Boyman

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? X Yes ___ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ___ Yes X No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ___ Yes X No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) ___ Yes X No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ___ Yes X No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ___ Yes X No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___ Yes X No

Do you know of a failure of the applicant to complete a residency training program(s)? ___ Yes X No

Does the applicant call upon consults when needed? X Yes ___ No

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

DR. KYM BOYMAN HAS PROVEN TO BE AN EXCEPTIONAL PHYSICIAN. HER SURGICAL SKILLS ARE EXCELLENT. SHE PRACTICES IN A KIND, METICULOUS FASHION. HER CLINICAL DECISIONS ARE BASED ON SOUND RESEARCH SUPPORTED THEORY. I RECOMMEND HER WITHOUT RESERVATION

The above report is based on:

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

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

I recommend KYM BOYMAN MD for licensure in Vermont.
Name of Physician

Signed: [signature] Date: 3-13-03

Print or Type Name and Title: DIANE CHARLAND MD

Reference Form #3
Return Directly to Board

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

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT. PAGE ONE OF TWO

Name of Applicant: Kym Boyman

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

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

Dr. Kym Boyman was at Fletcher Allen Health Care

from 6/99 to 6/03. During that time, he/she was

(List status in the Institution): resident in obstetrics & gynecology

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

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

Reference Form #3
Continued

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

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: Kym Boyman

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ✓ Yes ___ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ___ Yes ✓ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ___ Yes ✓ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is **not** minor.) ___ Yes ✓ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ___ Yes ✓ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ___ Yes ✓ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___ Yes ✓ No

Do you know of a failure of the applicant to complete a residency training program(s)? ___ Yes ✓ No

Does the applicant call upon consults when needed? ✓ Yes ___ No

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

The above report is based on:
- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other - Specify: ___

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

I recommend Julia Brock M.D. for licensure in Vermont.
Name of Physician

Signed: Julia Brock M.D. Date: 4/21/03

Print or Type Name and Title: JULIA BROCK, M.D.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

April 29, 2003

Attn: John Howland, Jr.
Vermont Board of Med. Practice
108 Cherry Street
Burlington, VT 05402

Re: Board Action Query Dated: April 29, 2003
Your Reference Number:
FSMB Batch Number: BQ789141

The following is a report of the search results from the Board Action Data Bank as of April 29, 2003 for practitioners submitted as part of the a referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 29, 2003

Item	Name	DOB	School	Yr/Grad	Request ID
1	BOYMAN, KYM	[redacted]	046010	1999	11099654