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

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
1391 Robinson Road
Ferrisburgh, VT 05456

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.
26 West Street
Bristol, VT 05443
(802) 453-3686

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
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.
26 West Street
Bristol, VT 05443

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: 1391 Robinson Rd
Ferrisburgh, VT 05456
Telephone: 802-877-6083

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) X **FEE of $400.00**

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

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

*3) X **BIRTH CERTIFICATE - Notarized**
Date of Birth: 9/10/1960 Place of Birth: St. Louis, Missouri

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

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

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

*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
12	10	1966

4: Your mailing address: (Check one: ✓ (Home address) Work address)

Care of:

Street: 1391 ROBINSON RD

Town/City: FERRISBURGH

State: VT

Zip Code: 05456-

5. Your electronic addresses:

Home telephone (optional): 802-877-6683 example: 802-555-1212

Work telephone: 802-847-1000 x 0379

E-mail (optional): Kym.Boyman@vtmednet.org

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

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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 you physical residence (city, state) in the past ten years? Perrisburgh, VT

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 12/10/66

* 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: 1391 Robinson Rd.

City, State, Zip Code: Ferrisburgh, VT 05456

Telephone Number: (802) 877-6683

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

Certified as a true and exact copy of original document.

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

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

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: 12 / 10 / 1966
Alt Name(s): Boyman, Kym Margaret

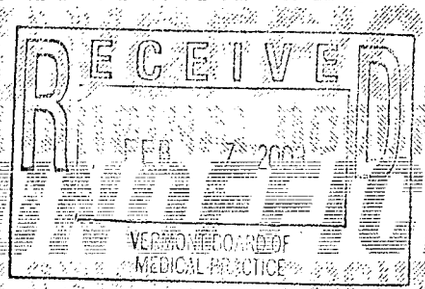
Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on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



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: Cheang 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	✓ 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.

American Medical Association

Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610

Profile Order Detail

03/18/2003

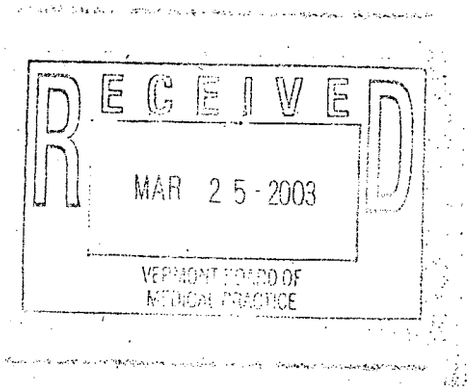
Vermont Board of Medical Practice
Jenny Audet
108 Cherry Street
Burlington, VT 05402

Profile Order Number: 1188264
Received Date: 03/17/2003
Balance*: $0.00

* - Negative balances are enclosed in parentheses

1 Profile processed.

- Kym Boyman



AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources **312 464-5199**
515 North State Street **312 464-5900 (fax)**
Chicago Illinois 60610

Request for Investigation

Dear Physician Profile Customer:

Thank you for using ***AMA Physician Profiles.*** AMA is committed to providing your organization with accurate physician information supporting your credentialing needs. If you should receive an AMA Physician Profile with discrepant information, please report the discrepancy to the AMA for immediate investigation.

AMA staff will contact the primary source(s) to verify the requested correction and/or change. No changes will be made to the AMA Physician Masterfile until verification from the primary source(s) is received. A letter detailing investigation outcome and an updated Physician Profile, when appropriate, will be mailed to the customer address below.

There is no additional charge for this service provided that the **Request for Investigation** is received within 30 days of the original order mail date.

Submitting a Request for Investigation:

- Make changes/corrections directly on a copy of the Physician Profile.
- Provide any supporting documents (DEA certificate, birth certificate, etc). This information will assist AMA staff with their investigation.
- Include a copy of this form when mailing or faxing discrepancy requests to the AMA.

Please don't hesitate to contact the AMA Physician Profile Unit at 312 464-5199 if you have any questions. Thank you in advance for your assistance.

Sincerely,

Department of Physician Data and Internet Services

Investigation Request ePhysician Profile Customer Account Information

Account #: _____

Name: Jenny Audet

Organization: Vermont Board of Medical Practice

Address: 108 Cherry Street

_____

_____

City/State/Zip: Burlington, VT 05402

Daytime phone: _____

**Copies of this form can be printed from the AMA ePhysician Profile Web site.*

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Name and Mailing Address:

KYM MARGARET BOYMAN MD
1391 ROBINSON RD
FERRISBURG VT 05456-9663

Primary Office Address:

111 COLCHESTER AVE
BURLINGTON VT 05401-1473

Phone: UNKNOWN

Birthdate: 12/10/1966
Birthplace: TOWN&COUNTRY, MO UNITED STATES OF AMERICA

Physician's Major Professional Activity: HOSPITAL BASED RESIDENTS - ALL YEARS

Practice Specialties Self Designated by the Physician:

Primary Specialty: OBSTETRIC & GYNECOLOGY
Secondary Specialty: UNSPECIFIED

AMA membership: NON MEMBER

Following Data Provided by the Primary Sources

Medical School:

UNIV OF VT COLL OF MED, BURLINGTON VT 05405 (VERIFIED)

Reported Year of Graduation: 1999 (VERIFIED)

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution: FLETCHER ALLEN HLTH CARE — **State:** VERMONT
Specialty : OBSTETRIC & GYNECOLOGY — 06/1999 - 06/2003 (VERIFIED)

Note: **Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program director(s). If additional information is required, please contact the program director(s).**

AMA Physician Profile (continued)

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AMA Physician Profile

License(s): State	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
VERMONT	MD	06/23/1999	06/30/2003	INACTIVE	RESIDENT	01/22/2003

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

ECFMG Certfication:

Applicant Number:

Note: **The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

Federal Drug Enforcement Administration:

TO DATE, FEDERAL DEA REGISTRATION STATUS IS UNKNOWN.

Note: **Many states require their own controlled substances registration/license. Please check with your state licensing authority as the AMA does not maintain this information.**

Specialty Board Certification(s):

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.

Certificate:

Certificate Type:

Effective: **Expiration:** **Last Reported:**

Note: **For certfication dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

AMA Physician Profile (continued)

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Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources
Attn: Physician Profile Unit
515 N. State Street
Chicago, IL 60610
312 464-5199
312 464-5900 (fax)

AMA Physician Profile (continued)

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National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

RESPONSE TO SELF-QUERY

A. REQUESTOR IDENTIFICATION

Requestor Name: BOYMAN, KYM MARGARET
Telephone: (802)877-6683
Address: FLETCHER ALLEN HEALTH CARE
1391 ROBINSON RD.
City, State, ZIP: FERRISBURGH, VT 05456
Country:

B. PAYMENT INFORMATION

Payment Type: CREDIT CARD
Account Number: [redacted]
Expiration Date: 02/2006
Transaction Date: 03/17/2003
Transaction Number: 5500000028706990
Total Charge: $10.00

C. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: BOYMAN, KYM MARGARET
Gender: FEMALE
Date of Birth: 12/10/1966
Other Name(s) Used:
Organization Name: FLETCHER ALLEN HEALTH CARE
Organization Type: GENERAL/ACUTE CARE HOSPITAL (301)
Other, as Specified:
Home or Work Address: 1391 ROBINSON RD.
City, State, ZIP: FERRISBURGH, VT 05456
Country:
Social Security Numbers (SSN): [redacted]
Professional School(s) & Year(s) of Graduation: UNIVERSITY OF VERMONT 1999
Occupation/Field of Licensure (Code): PHYSICIAN INTERN/RESIDENT (MD) (015)
State License Numbers, State of Licensure: NO LICENSE,
Other, as Specified:
Specialty:
Drug Enforcement Administration (DEA) Numbers:
National Provider Identifiers (NPI):

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www.npdb-hipdb.com

Federal Employer Identification Numbers (FEIN):

Unique Physician Identification Numbers (UPIN):

D. SEARCH RESULT

Based on the subject identification information provided by you in Section C above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

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	12/10/1966	046010	1999	11099654