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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
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- 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: 12 / 10 / 1966  
Month / Day / Year

3. Home Address:

<u>1391 Robinson Rd.</u>	
(Street)	OCT 18 2004
<u>Ferrisburgh</u>	<u>VT</u>
(City)	(State)
	<u>05456</u>
	(Zip)

4. Work Address:

~~1391 ROBINSON ROAD~~  
~~FERRISBURGH, VT 05456~~

<u>23 Mansfield Ave.</u>	
(Street)	
<u>Burlington</u>	<u>VT</u>
(City)	(State)
	<u>05401</u>
	(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: (802) 877-6683

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

8. E-mail address:

Kym. boyman @ vtmednet.org

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 Have you ever withdrawn an application for a license to practice medicine or any other healing art?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)
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**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
		<input type="checkbox"/> yes <input checked="" type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> 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)
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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 - ACob 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

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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         | 12 Leave of absence                       |
| 02 Suspension of right or privilege         | 13 Withdrawal of an application           |
| 03 Censure                                  | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition          | 15 Medical Records Suspension             |
| 05 Restriction of right or privilege        | 16 Probation                              |
| 06 Non-renewal of right or privilege        | 17 Assurance of Discontinuance            |
| 07 Fine                                     | 18 Consent Agreement                      |
| 08 Required performance of public service   | 19 Letter of Agreement                    |
| 09 Education/Training/Counseling/Monitoring | 20 Expulsion from Membership              |
| 10 Denial of rights or privilege            | 21 Reprimand                              |
| 11 Resignation                              | 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  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 November 18th, 1991

18.2-404

DATE

did unlawfully in violation of Section

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 Officer P. J. O'Hara

FIN#1618 Fairfax County Police Dept.

**WARREN B. BROWN** Plaintiff

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

About 7:15 A.M. November 18th, 1991

DATE AND TIME ISSUED

*Warren B. Brown*  
- D. CLERK -  
MARGY LANE, CLERK  
FAIRFAX COUNTY GENERAL DISTRICT COURT

## SUMMONS (If authorized above and by serving officer)

You are hereby commanded to appear before this court located at

I promise to appear in accordance with this Summons.

BY: *Warren B. Brown*  
Original relative in the Clerk's Office of the General District Court of Fairfax County, Virginia

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-314 690(11-9-91S 7-91)

December 13th, 1991 9:39 A.M.

4110 CHAIN BRIDGE ROAD FAIRFAX VA 22031

ACCUSED: Boyman, Kym Margaret

LAST NAME, FIRST NAME, MIDDLE INITIAL

14233 Grand Pre Street, Apt 2204

ADDRESS LOCATION

Aspen Hill, Maryland 20906

COMPLETE DATA BELOW IF KNOWN

RAFE	SEX	NO	BORN	HT	WT	HAIR
W	F	12	10/66	5	8	135

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

OHARA, P.I.

ARRESTING OFFICER

11/18 FAX Co. P.D. 029

BADGE NO. AGENCY AND JURISDICTION

SHERIFF

Attorney for the Accused:

SP-11-P

*Don G. [Signature]*  
*g p o/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 .....

CK#: 5444

RELATED CASES: -

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

ORDER the charge dismissed  
 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 .....

BOND REFUNDED; condition of suspended sentence.  
TO: *100% by performed for* ..... hours of community service to

AMT: \$ 1000  
 in addition to other sentence provisions  
 to be credited against fines and cost

ID: *McMurry* at \$ ..... /hr A COURT TESTER: 132 CIOCF  
HARRIS LAKE, CLERK

DATE: 11/5/92  
FAMILY COUNTY GENERAL DIST. APPT. ATTY.  
DISTRICT COURT

REPAIR CLERK 125 WEIGHING FEE  
CLERK: *ML*  
of the General District Court  
District Court, Virginia

113 WITNESS FEE  
125 WEIGHING FEE

APPEAL BOND \$ .....  
appeal noted on .....  
**CASH BOND**

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

BY DEFENDANT  
 BY THIRD PARTY

TOTAL \$ .....  
109 INTEREST CHARGE .....  
TOTAL WITH INTEREST CHARGE \$ .....  
INTEREST CHARGE \$ .....

DATE PAID RECEIPT NO

JUDGE D.J. SMITH

9-11-92

1000

Plea? Yes  No

Date \_\_\_\_\_

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

Name of Licensing Board \_\_\_\_\_ Date \_\_\_\_\_

Location of Licensing Board \_\_\_\_\_

Circumstances \_\_\_\_\_

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

Treating organization \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Dates of illness or dependency \_\_\_\_\_ to \_\_\_\_\_

Dates of treatment \_\_\_\_\_ to \_\_\_\_\_

Name of Rehabilitation/Professional Assistance or Monitoring Program \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Contact person at Program \_\_\_\_\_

**(Question 31) Medical Malpractice Claim**

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:**

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**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 12/10/1966

\* 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 \_\_\_\_\_