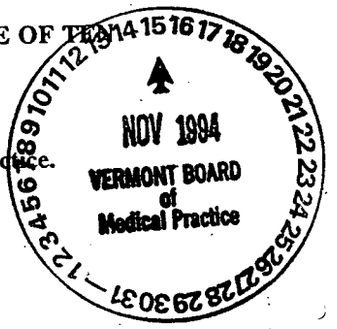
042-5990 Smith, Susan

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



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

Susan Smith
Women's Choice Gynecologic Associates
23 Mansfield Avenue
Burlington VT 05401

****

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

-Thank you for your cooperation.

SECTION I

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

1. Name: Smith, Susan

2. Vermont License Number: 042-0005990

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

4. Home Address:

City, State, Zip Code:

5. Office Address: Women's Choice Gynecologic Associates
23 Mansfield Avenue
City, State, Zip Code: Burlington VT 05401

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

6. Daytime Telephone Number: 802-863-9001

7. Date of Birth: 01/26/44

8. Place of Birth: San Francisco, California

9. Sex (M/F): F

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SECTION I CONTINUED

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

11. Undergraduate Degree: (B.A., B.S., etc.): BS Year of Graduation: 1969

Major Course of Study: ZOOLOGY

Degree Granting Institution: UNIV MICHIGAN ANN AR

Location: ANN ARBOR , MI USA

First Institution (If transfer):_____

Location:_____

12. Medical Degree: (M.D. or Other, please specify): MD Year of Graduation: 1976

Degree Granting Medical School: UNIV MICHIGAN ANN AR

Location: ANN ARBOR , MI USA

First Medical School (If transfer):_____

Location:_____

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

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

15. Other states where you hold an active license to practice: applying for N.H. license

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

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

	Specialty Code(s) (See the list of specialty codes.)	**American Board of Medical Specialties Certified (Yes or No)**	**Year Certified/Recertified**
(a)	1 1 0 1	YES	1982 /
(b)	___ ___ ___ ___		/
(c)	___ ___ ___ ___		/

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SECTION I CONTINUED

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

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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

Major Course of Study:_____

Degree Granting Institution:_____

Location:_____

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SECTION I CONTINUED

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

	Institution	City	State	Country
(a)	Medical Center Hospital-Vt	Burlington	Vt	USA

Specialty Code (See attached list of specialty codes)	Year Completed
1101	1980

	Institution	City	State	Country
(b)				

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

	Institution	City	State	Country
(a)				

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

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

Name of P.A.	Check if: Primary	and/or Secondary

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SECTION I CONTINUED

21. Are you now in a collaborative relationship with a nurse practitioner? _____Yes __X__No
If yes, please list the name(s) of the nurse practitioner(s):

_____

_____

_____

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1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF TEN

SECTION I CONTINUED

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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
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SECTION II: PLEASE CHECK YES OR NO.
A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.

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

During the past two years:

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

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

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

4. Have you been dependent upon alcohol or drugs? [redacted]

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

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

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

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

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

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

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

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

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

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

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

SECTION II CONTINUED

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

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

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
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SECTION III

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

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

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

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

OR

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

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

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

OR

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

(3) SOCIAL SECURITY NUMBER: [redacted]

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

(4) STATEMENT OF APPLICANT

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

Date: 10/25/94 **Signature:** Susan Day Smith

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

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

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

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

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

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

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

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

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VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

To be completed only by physicians practicing in Vermont.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

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

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

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

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
   (Month/Year) 8 / 80

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
   (Month/Year) 8 / 80

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

6. What is your Unique Physician Identification Number (UPIN)? D0 3217

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

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

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

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

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

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): Women's Choice Gynecologic Associates
Street Address: 23 Mansfield Ave
Town: Burlington VT 05401 Zip Code: _____

Is your practice at this site affiliated with an **IPA HMO**? ___Yes ___No contracted provider for CHP + VMC
Is your practice at this site affiliated with a **Group/Staff HMO**? ___Yes ___No ? as in the employ of CHP? - NO
Do you engage in **teaching** at this site? X Yes ___No
Do you engage in **research** at this site? X Yes ___No

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
4011	45	2	YES	YES	YES	YES

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

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
X	General gynecological medical care	45
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): Planned Parenthood Northern New England St Albans Site
Street Address: 80 Fairfield St
Town: St Albans Vt Zip Code: 05478

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

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

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

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

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

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

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

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
X	General gynecological medical care	1
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(c). **WORK SITE: NUMBER THREE**

Name of Practice(s): Planned Parenthood Northern New England Barre Site
Street Address: 90 Washington St
Town: Barre VT Zip Code: 05641

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

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

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

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

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

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** patients in this specialty? YES or NO
4011	1/3	12	YES	YES	YES	YES

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

	Service	**Hours**
	General pediatric medical care	
	General adolescent medical Care	
	General adult medical care	
	General geriatric medical care	
X	General gynecological medical care	1/3
	General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

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

Name of Practice(s): _____

Street Address: _____

Town: _____ Zip Code: _____

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

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

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

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

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

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

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

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