3336

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

2002 PHYSICIAN'S LICENSE RENEWAL APPLICATION

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

Instructions

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

Part I - Identity Questions

Vermont Physician's License Number: 042- 0 0 0 6 9 9 0

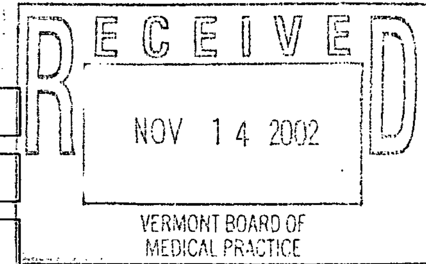
1. Print your full name as you wish it to appear on the license:

First name: SUSAN

Middle name: FAY

Last name: SMITH

Extension:



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

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

3. Your date of birth:

M	M	D	D	Y	Y	Y	Y
0	1	2	6	1	9	4	4

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

Care of: VERMONT WOMEN'S CHOICE

Street: 23 MANSFIELD AVENUE

Town/City: BURLINGTON

State: VT

Zip Code: 05401 -

5. Your electronic addresses:

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

Work telephone: 802 - 863 - 9001 x

E-mail (optional):

6. Were you in active practice in Vermont in the past 12 Months? [X] Yes [ ] No

7. Are you currently participating in residency or fellowship training [ ] Yes [X] No

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

If yes, complete the section below:

State	License Number	Date Issued M M	D D	Y Y Y Y	Status (Active, inactive, other)
NH	9340	12	07	1994	ACTIVE
ME	015518	02	08	2001	ACTIVE

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

Part II - Licensure and Practice Questions

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

9. Have you ever applied for and been denied a license to practice medicine or any other healing art?
   [ ] **Yes** [X] **No**

10. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
   [ ] **Yes** [X] **No**

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

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

13. Have you ever been denied the privilege of taking an examination before any state medical examining board?
   [ ] **Yes** [X] **No**

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

Part III - Confidential Section

Part III is exempt from public disclosure

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

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

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

MEDICAL QUESTIONS

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

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

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

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

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

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

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

IMPORTANT

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-4393 (a confidential line).

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

Part IV - Statutory Profile Questions

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

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

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

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

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

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

25. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)] NOT APPLICABLE

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

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

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

26. **Vertmont 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.) NOT APPLICABLE

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

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

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

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states within the past 10 years. **Please provide copies of papers fully documenting these matters.** NOT APPLICABLE

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

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

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

A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges within the past 10 years that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.** NOT APPLICABLE

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.**

NOT APPLICABLE

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

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

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

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.** NOT APPLICABLE

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.** NOT APPLICABLE

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

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

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

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

School	City	State	Year of Graduation
University of Michigan Med. School	Ann Arbor	MI	1976

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

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

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

School/Institution	Specialty	City	State	Year of Graduation
Univ of Vt / MCHV	OB Gyn	Burlington	Vt	1980

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

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

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1101	OB GYN	☒ yes ☐ no	The American Board of OB Gyn	1982	
		☐ yes ☐ no			
		☐ yes ☐ no			

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

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

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

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

List all hospitals where you currently have hospital staff privileges:

Name	City	State	Year Started
Fletcher Allen Health Care (Medical Center Hospital of VT)	Burlington	VT	1980

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

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

A. **Appointments**

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

School	City	State	Nature of Appointment	From (year)	To (year)
Univ of Vermont College of Medicine Department of OB/Gyn	Burlington	VT	Assistant Prof.	1980	10/1993
— " —			clinical Assistant Prof.	12/1993	1996
— " —			clinical Associate Prof.	1996	present

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

B. **Teaching**

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

School/Institution	City	State	Nature of Teaching	From (year)	To (year)
University of VT College of Medicine	Burlington	VT	occasional didactic presentations	1992	present
— " —			regular supervision of resident clinics	~1996	present
—			clinical teaching in emergency department, OR + inpt wards	1992	present

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

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

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

Title	Publication	Year

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

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

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

Activities or Awards

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

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

What is the location of your primary practice setting?

Town or City: BURLINGTON

State: VT

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

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

☐ **Yes** ☒ **No**

If yes, please describe here the translating services available:

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

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

A. **Medicaid participation**
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. **New Medicaid Patients**
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V - Clinical Practice Questions

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

- ☒ Active in clinical practice (in direct patient care) in Vermont
- ☐ Active in clinical practice (in direct patient care) outside Vermont
- ☐ Administration
- ☒ Teaching medical students and residents
- ☐ Research
- ☐ Not currently in active practice

Are you currently participating in residency or fellowship training? ☐ Yes ☒ No (if this means "I am a resident fellow")

BEFORE YOU CONTINUE:

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

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

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

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

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

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

Site 1: BURLINGTON VT

Site 2:

Site 3:

Site 4:

Question	Site 1	Site 2	Site 3	Site 4
B. Number of weeks per year that you spend providing direct patient care at this site: (Full-time is considered to be 48 weeks / year)	44			

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

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

	Site 1	Site 2	Site 3	Site 4
Specialty Code	4 0 1 1			
(Specialty name, if code unknown)	GYN			
Hours per week				
Secondary Specialty, if any				
Hours per week in secondary specialty				
Tertiary Specialty, if any				
Hours per week in tertiary specialty				

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

Part VI - Signature

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

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

Date: 10/8/02

Applicant's Signature

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

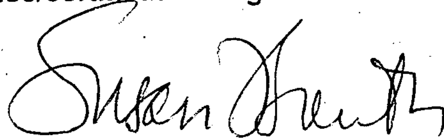
✓ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* Date of Birth 1 / 26 / 44

* 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.

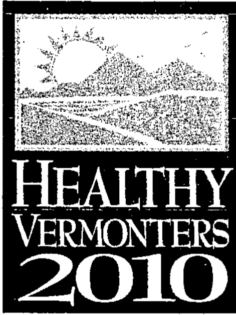
STATEMENT OF APPLICANT

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

042-0005990

Susan Smith MD
Women's Choice Gynecologic Assoc.
23 Mansfield Avenue
Burlington, VT 05401



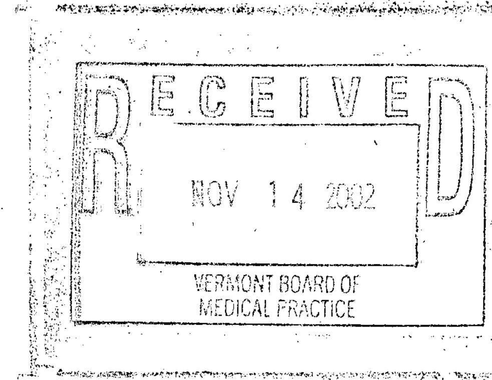
Vermont Department of Health
Board of Medical Practice

Agency of Human Services

November 1, 2002

Dear Physician:

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



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

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

Thank you.

Sincerely,

Medical Practice Board
(802) 657-4220

Enclosures